Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 1. Decede Physician/ 2 800 Medical 4a. Facility Name (if not institution, and number. City, Town, or Location of Death Examiner nwes 405 Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday, **Funeral** Days Min (Month, Day, Year Country 1 ★ M 2 □ F 020-50-6190 52 MARYLAND Director -17-1957 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No N/A BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21216 USA 740 POPLAR GROVE ST APT 7A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) GOODWILL INDUSTRIES LABORER Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ DELORES MILLINGS ARL\_LYLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 19a. Informant's Name/Relationship (Type, Print) 740 POPLAR GROVE ST. APT 9C BALTIMORE, MARYLAND DELORES MIXITINGS (MOTHER) 20a. Method of Dispos 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Crem 4 Donation 5 Dether (Specify) CEMETERY 5-14-2010 BALTIMORE, MARYLAND AHTAKOC<sup>ees</sup>nesi<sup>k</sup> HIBNER22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of F D. tus 721-27 N. MONROE ST. BALTIMORE. nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi heros ardiovascular ause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has how how have a second or the funeral Director. been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Day Pregnant at time of death 2 No page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Yes 2 🔀 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 **X** No ၉ 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) Signatu 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

3

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03377 State of Maryland / Department of Health and Mental Hygiene Robert D. Mitchell 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Medical Examiner Robert May 2, 2010 D. Mitchell 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Brandvwine Prince George's 8800 Charm Court If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Director 577-76-8245 53 11/28/1956 1 X M 2 F Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State s 23a or 28a-f sbow at notified at once. Prince Georges Brandywine 1 and 2 should be filed within 72 hours after death with the Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 這 8800 Charm Ct. 20613 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Black White, etc. Armed Forces? 1 Never Married 2 Married X Yes ū f Yes, Give Year or Dates: 3 Widowed 4 X Divorced 1 Yes 2 No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry other than "natur Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th US Army Veteran of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked æ Robert Henry Mitchell Mildred Johnson 19a. Informant's Name/Relationship (Type, Print.) မ Mildred Mitchell - Mother 315 34th Pl. NE Washington, 20a. Method of Disposition 20b Place of Disposition (Name of cemetery Date timore, crematory or other place) Pages 1 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans 5-11-2010 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 4308 Suitland Rd. **Physician** failure. List only one cause on each line /Medical a. Gunshot Wounds of Head and Left Leg Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical attending physician a UNPENDED AMENDED Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ē ۵. Completed Records, 24a Was an autopsy has b ✓ Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical æ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes No 28a Date of Injury (Month, Day Year) May 2, 2010 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot Natural 1522 hrs Yes 2 V No Pending 2 Investigation Accident

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DC 20019 20c. Location - City or Town, State Cheltenham, MD. <sup>22</sup>Mars and Adress of Fullyeral HOme of Maryland Suitland, MD. 20746 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Year 23e, Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital Other Nursing Home 5 Residence 6 🗸 Other Scene 28d. Describe how injury occurred Certification Director: d in by the f 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. An 24 hou...
The Funeral Du. Could not be Suicide or Town, State) 8800 Charm Court, Brandywine, MD determined (Specify) Single Family Home 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E. May 3, 2010 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD 32. Registrar's Signature State Registrar **ORIGINAL** OCME

1551 hrs

10d. Inside City Limits

1 Yes 2 X No

Country)

**Black** 

DHMH 17 Rev 1/2001 **OCME 2006** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2010 GEORGIA MAE MURPHY 20:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGES PRINCE GEORGES HOSPITAL CHEVERLY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Month, Day, 1 □ M 2 🖾 F Months Days Hours Min. Director 579-66-9578 Î929 81 SC Usual Residence of Decedent 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Menthal Hygene. It ment of Health and Menthal Hygene. It ant. If frem a marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No MDPrince Georges Capitol Heights 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 4011 Vine St. 20743 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Families 8th Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George Caldwell Tallahassee Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlease Johnson - Daughter 12602 Kings Pl. Mitchellville, Md. 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oti 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery: 5-15-2010 Brentwood, MD. Fundral Service Licensee Marshall's Funeral Home of Maryland, Suitland Rd. Suitland, MD. 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SEP Ph sician/ TI disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PIRATORYFAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events RRHYTHMIA After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical X Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Vear 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 🗌 Yes 2 🙀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after deau. ral Director: After X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORAPATI 3001 Hospital Dr. CHANDRASEKHAR Cheverly, MD. 20785 31. Date file State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 54 AM 2010 Brian Eugene Nickens Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore n/a Union Memorial Hospital 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 5. Social Security Number 216–82–1099 **Funeral** Country) 1 X M 2 □ F Days Hours Min. 12/06/1963 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State n/a Baltimore Maryland 1 X Yes 2 No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21212 USA 902 St. Dunstans Road Apt #2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Specify.Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Facilities Management Janitorial Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alda Louise Bright Arthur William Nickens Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 St. Dunstans Rd APT #2 Baltimore, MD 21212 Valerie Brailford-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Baltimore Crematory 105.17.2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) tural of Funeral Salvia John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 21. Sig Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as consequen A of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to de as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy berformed' death? 2 No certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? injury 5  $\square$  Pending Natural Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date sid ned (Month, Day, Year) 29c. License number 29b. Signature 2011 30. Name and address of persor e of death (Item 23a) (Type, Prin REGUR 31. Date filed (Month, Day,

State

Registrar

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State of Maryland / Department of Health and Mental Hygiene, State of Per me, 903, 05/13/2010dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Richard Campion Peach 2010 7:54P M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Sept. 24, Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Min. 1**X**M 2 □ F 76 Months Hours 213-30-5953 Maryland Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov 10a State filed within 72 hours after death with the Maryland Examiner must be notified at Director Parkville 1XXYes 2 □ No 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number Funeral items 23a 21234 United States 2819 Rosalie Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces?
X Yes 2 No Black, White, etc ò þ 1 Never Married 2 X Married White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Baltimore City al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Letter Carrier Postal Services Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) ပ Cecelia Resau John I. Peach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2819 Rosalie Avenue, Parkville, Maryland 21234 Barbara L. Peach - Spouse 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parkville, Maryland May 11, 2010 4 Donation 5 Other (Specify) Parkwood Cemetery 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Parkville Signature of Funeral Service Licenses 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ hoking bolus 00 tood disease or condition Medical resulting in death) Due to (or as a cons dence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions. Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) at has been signed by the a pege 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No After this certificat completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of injury 28b. Time of pinjury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 🗶 No Subject choked on food bolus. 05/07/2010 Unknown M within 24 hours after death. To the Funeral Director: A Investigation Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **2819 Rosalie Avenue** 4 Homicide determined Home Baltimore,MD Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Centifying reproduct to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Centifying hurse Practice at 1 to best of my investigation, in my opinion, death and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D00626

3+1

State Registrar 30. Name and address of person who completed cause

31. Date filed (Month, Day, Year)

61/de th (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 7:35 P M 8 2010 May Phillips Rose Marie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Carroll Hospital Center Westminster Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Months Hours Days 1 □ M 2 🕱 F 73 1, 1936 Pennsylvania Nov. 219-26-3269 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 TNo Union Bridge Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21791 12757 Bunker Hill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) private home 12 <u>daycare</u> provider 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Smith Harley I. Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Union Bridge, MD 21791 Donald L. Phillips Sr./ husband 12757 Bunker Hill Rd. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/12/2010 | nr. Linwood, MD Pipe Creek Cemetery 22. Name and Address of Facility of Funeral Service Di Hartzler Funeral Home attaine ( 6 E. Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that exused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ulmonon Hrus Due to (or as a consequence of). 1000000 Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

2

Completed

Be

ပ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentia Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, If a Medical Examment with the annual control of the straumatic event, If a Medical Examment with the language.

Saltimore, Maryland 21215-0036

burialphysician the attending p detached signed t page 2 should has certificate director. after death. Director: After this funeral

filled in by the

0

Registrar

State

24 hours a

the

within 24 hor To the Fune completely fi

Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760.

Examine Physician/Medical þ Completed Be

Certification: To

Medical

IF FEMALE:

29a. Certifier

in the past 12 months?

1 ☐ Yes 2 🙀 No 9 Unknown

28d. Describe how injury occurred

1 ☐ Yes 2 🗷 No

1 ☐ Yes 2 ☐ No

MD 21157

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 NOA

27, Manner of Death 5 Pending investigation 1 Natural 2 Accident

6 ☐ Could not be 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Westminster

(Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Rd.

Stephen 31. Date filed (Month, Day, Year) 13 2010

MD Sikorski 32. Registrar's Signature

912

For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number Examiner altimore HOSPITE Funeral 218-46-0564 Director Usual Residence of Decedent or 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death when the permit, Page 1 and 2 should be filed within 72 hours after death when tall Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f should protect that the marked other than "natural", or items 23a or 28a-f should be not the filed at the protect that the marked other than marked other than marked other than "natural", or items 23a or 28a-f should be not shoul 10a. State 10b. County 10c. City, Town or Location Director MD N/A Baltimore 10e Street and Number 2723 Atkinson Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? þ 1 Never Married 2 Married Yes, Give No 21215-0036 Completed 3 Widowed 4 XXivorced Year or Dates. Virginia 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last) Glen R. Barnett 19a. Informant's Name/Relationship (Type, Print) Harry Sather (Son) Baltimore, 20a. Method of Disposition 1 Donation 5 Other (Specify) 21. Signature of Fineral Service Unisal shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician neumonia disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown signed by the at id be detached for Pregnant at time of death Unknown þ Completed page 2 After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? 2 🖬 No မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be determined To the Hospital Medical 29a. Certifier (Check 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Virginia Lee Pompanio 33 4b. City-Town, or Location of Death 4c. County of Death N/A Daltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) 10,1947 10d. Inside City Limits 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 21211 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 This Specify. Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Electronics Rockwell-Collins 18. Mother's Name (First, Middle, Maiden Surname) Hilda Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Newcomb Way Baltimore, MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Meadowridge Memorial 5/15/10 Elkridge, MD Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 Tes 2 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 00069 31. Date filed (Month, Day, Year 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 4:16 AM 2010 BRIDGETTE Y. PIERCE Mai /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Baltimore inai Hospital N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 | M 2 | XF Days Hours Min Director 217-74-8894 50 3-17-1960 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fiem 278 marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is wateral Exprise rough and any injury or other traumatic event, it is wateral Exprise rough. Director 1X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3824 BOWERS AVE. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) KNOWN OR -12-CHILDCARE PROVIDER DAYCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE PIERCE ပ္ ANGELA DOYLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGELA D. PLERCE (MOTHER) 3824 BOWERS AVE. BALTIMORE, MARYLAND 21207 20a. Method of Disposit 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 HBurial 2 □ 3 Removal from State Cremation 4 ☐ Donation 5 Other (Specify) MARYLAND NATIONAL 5-14-2010 LAUREL, MARYLAND D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cause (Final Immedi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed cate has b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) DOVE MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 16 DERE State Registrar's S Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Maryla		artment of F tificate of I			giene Reg. No.	15010		
81	1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death					
Physician /Medical	Sr. Mary Catherine Rogers	Month May	5 2010	12:50 P <sup>M</sup>					
Examiner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	h	4c. County of Dea			
	Marian Hall  5. Social Security Number 6. Sex 7. Age (In v		Marrio If Under 1 Year	ttsville		Howard			
Funeral Director	5. Social Security Number 6. Sex 7. Age (In y 2 🖂 F 74	vrs. last birthday) Yrs.	Months Days	Hours Min.		th ay, Year) 9. Bit C	thplace (State or Foreign		
	Usual Residence of Decedent				Dec.29	, 1933 Mai	yland		
rylan	10a. State 10b. County 10c.	City, Town or Lo	cation				10d. Inside City Limits		
Ba-f s	MD Howard 1	Marriott	sville				1 □Yes 22K∑No		
vith the Marr to or 28a-f sh be notified Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?		
s 23s	1525 Marriottsville Road			1104		USA			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its Modical Exercitive roust bandified at once.  To Be Completed by Funeral Director	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hi FYes, specify Cuba □Yes 2☑No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - Am Black, Whit Specify: W	e, etc.		
5-0 72 ho	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation	rkina	16b. Kind of Business	Industry		
121215-003( ed within 72 hours a tygiene. Per than "natural", o. It, It's Modical Exer. Completed by	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of NOT use retired		King				
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and abe fill set off eed off	William Rogers				ne (First, Middle, n Phelan	Maiden Surname)			
aryla should nd Mer marke marke	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	n Address (Street a	-		er, City or Town, State,	Zin Cada)		
M62 alth a 27 is or trau	Sr. Frances McCabe					riottsville			
or Her		b. Place of Dispos		-	Date	20c. Location - City or			
Page nent nent ury or	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) N		dral Cem	· .	-2010	Baltimore,	Maryland		
Balt  permit. Depart Import any inj once.	21. Signature of Funeral Sorvice Licensee	22	Name and Addres	s of Facility St	erling A	shton Schwa	ab Witzke		
ш аоғаа	1 XC Tallne	1	630 Edmor	<u>ndson Av</u>	enue: Ca	tonsville.	MD 21228		
	23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dying	g, such as cardia	or respiratory ar	rrest,	Approximate Interval Between Onset and Death		
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)  A. PANCREATIC CANCER								
Examiner	Due to (or as a cons	sequence of):							
	Sequentially list conditions, if an, leading to immediate cause. Enter Underlying	sequence of):							
0, 4 executed an and rial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events								
58760, ¢ ficate be executed physician and s the burial-transit	resulting in death) Last Due to (or as a cons	equence of):							
18760, icate be exphysician at the burial-dical Ex	d			_			· ·		
X 6	IF FEMALE:								
I Records, P.O. Box 6 The law requires that the death certifing tate has been signed by the attending tage 2 should be detached for use as completed by Physician/Mec	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year		
ecords, P aw requires that s been signed b 2 should be deta	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause give	n in Part I.	23e. Did to	obacco use contribute to	the cause of death?		
ord equir sen si ould b					1 🗆 Y	′es 2 <mark>M</mark> No 3∏Pi	obably 4 Unknown		
							topsy findings available completion of cause of		
of Vital F Physician: The this certificate al director, pag	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only or		2 200		
Of Physical this call direction To	1 ☐ Yes 2 ♣No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient		4 Nursing H	ome 5 Resid	lence 6 ☐ Other (Spe	cify)		
ding After funer	27. Manner of Death  1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	low injury occurred			
Atten death death ctor: y the	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At	home farm stre		es 2□No	28f Location (C	Street and Number or Ru	ural Bauta Alumbar		
Division of tall or Attending Phys is after death. at Director: After this led in by the funeral director. To Certification: To	4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	cify)	or, ractory, critico		City or Tow	n, State)	rai noute Number,		
Division of Vita Vita to the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be C	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my k 2 **Medical Examiner: On the basis of examiner and manner stated.	nowledge, death ination and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occu	e, and due to the or	cause(s) and manner a date and place, and due	s stated. to the cause(s)		
To the within To the complex complex Me	29b. Signature and title of certifier		29c. License		2	29d. Date signed (Mont	n, Day, Year)		
	I think down		1 29	071		577/10			
	30. Name and address of person who completed cause of death (It	mem 23a) (Type, P	rint) N CHOIC	CE / ANT	#302	BALTIM	DRE 21201		
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Sign AV 13 2010					1101700			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY IDELLA ELIZABETH RIDGLEY 2010 0017 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD CO UPPER CHESAPEAKE MEDICAL CENTER 8. Date of Birth (Month, Day, 1) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**XX** Months Days Hours Min. Director 84 MARYLAND 217-20-0373 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXVo FOREST HILL MARYLAND HARFORD CO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1905 LINCOLN RD. 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa any injury or other traumatic event, the Medical Exa one. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 XXWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th grade HOMEMAKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE TOLIVER EVA TOLIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Gray/Son 116 Hutchins Ct., Havre de Grace, Md. 21078 Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Berkley Cemetery 05-15-10 DARLINGTON, MARYLAND 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, 23a. Part 1. Enter the di PHILADELPHIA BLVD, ABERDEEN, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition MKnown Medical resulting in death) Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the birinal-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Records, cardiac arrest 1 Yes 2 No 3 Probably 4 Unknown respiratory distress syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Ridg Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 2 **N**O 1 Yes Other: 1 Mnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Detailing in Notice and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continues Practicans: (Check Certifying Nurse Practioner: To the best of my throwledge, death occurred at the time, data and place, and due to the cause(s) and mainler as state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00065421 May, 11, 2010 MD

Registrar
DHMH 17 Rev 7/2009

State

500 Upper Chesapeake Drive, Bel Air, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Christa Fishler,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Pegistrar No. Reg. No. Name (First, Middle, Last) Date of Death Time of Death Physician /Medical (If not institution, give street and number) or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 F Months 59 016-40-8225 MA Director July 11, 1950 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at PA Berks Reading 1 Yes 2 X No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 165 Valley Green Circle 19610 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Δ <u>Business Owner</u> Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) injury or other traumatic event, Be Daniel Joseph Reardon Helen Murphy မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:3 Department of Health an Important: If item 27 is any injury or other trau Danielle E. Reardon / Daughter 2226 McKinley Avenue, Reading, PA 19609 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State remetery, crematory or other place)
Final Journey Crem. 4/27/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature ∞Dorota Marshall Moustian 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VIEWOZIZKO disease or condition resulting in death) nza /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER nding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be director, page 2 sl autopsy performe 2 No 1 Tyes Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 2 6 Other (Specify) this 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral D filled (s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address

31. Date filed (Mo

a

parker

600 North Wolfe St, Baltimore, MD, 21287

who completed cause of death (Item 23a) (Type, Print)

32

egistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 1 0

even Reeder		State of Maryland / Department of Health and 1-For State Certificate of Death	d Mental Hy	J	eg. No.	
Physic edical Exam				2. Date of Deat Month May 7, 201	Day Year	3. Time of Death 1108 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or leading to the control of t	Location of Death		4c. County of Dear	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 212-60-4720 1\overline{X}M 2\overline{F} 58 Yrs. Months Days		8. Date of Birt	Forei	rthplace (State or gn <sup>Duntry</sup> Maryland
d how any	Ĺ	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  MD  n/a  Baltimore				10d. Inside City Limit
5-0036 Suitin 72 hours after death with the Maryland styled with 72 hours after death with the Maryland other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 2323 Maryland Avenue Apt 3C 2121	8	10	og. Citizen of What Cou	
r death or iter must	Funeral	11. Marital Status unk 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Narried Narri	, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
5-0036 lied within 72 hours after Hygiene. I other than "natural", the Medical Examiner.	leted by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ion (Give kind of wo		16b. Kind of Business.	Industry
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	12 Volunteer  17. Father's Name (First, Middle, Last)unk 1	18.Mother's Name (	First, Middle, M	Homeless S	Shelter 
	To Be		Ruth Ames	3		7-0-10
O 54 54 25 1 1 1	_	Shanell Ricks-Daughter 1531 Barclay S	Street Ba	ltimore	, MD 21202	
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Memal I Important: If iten 27 is marked injury or other traumatic event,		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cerematory or other place)  Baltimore Cremator	y 5.1	7.2010	20c. Location - City of Baltimore	, MD
Bal permii Depar Impoi	ļ,	21 Signature of Funeral Service Licensee John L. Will 4517 Park H	Teiahts Ar	ve Balt	imore.MD	P.A. 21215
Physician /Medical Examiner		2 Part I. Enler the disease, or complications that caused the death. Do not enter the mode of dying, s failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular Due to (or as a consequence of):			st, shock, or heart	Approximate Interva Between Onset and Death
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):				
60, tte be executed hysician and e burial - transit	Medical E	M UNPENDED X AMENDED, 23a, 27, permE, G903 5/26 #9 & 10d, per FH g903 5/26	6/10 TT			
Ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ar death. cetor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of deliver Month	y Day Year		
S, P.O. E ires that the a signed by the detached	ð	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	iven in Part I.		pacco use contribute to	
Record: The law requirant has been page 2 shoul	Completed			24a. Was a autops perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of eas 2 No
Vital Reystician: The his certificate director, page	Be		of Death (Check on	<del></del>	Residence 6 🗸 Othe	r Scene
ion of ttending Ph leath. tor: After t	ation: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury			ow injury occurred	
`S Pagigi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office but (Specify)		or Town, Sta		
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	te and place, and de death occurred at t	ue to the cause he time, date a	(s) and manner as stat nd place, and due to th	ed. le cause(s)
	ž	29b. Signature and title of certifier  O.C.M			29d. Date signed (Mo	nth, Day,Year)
	1 (0	Name and address of person who completed cause of deeth (Item 23a)     Victor Weedn MD JD	altimore, MD 2	1201		
St Regist		31. Date filed (Month, Day, Year)  NAY 13 2010  2. Registrer's Signature				
MH 17 Rev 1/2	001	OCME ORIGINAL				

10-03630 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene James Edward Sigmon, Jr. 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ 0610 hrs Medical Examiner May 11, 2010 James Edward Sigmon, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Dundalk **Baltimore County** 7990 St. Monica Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 213-68-8318 Director ct.18,1956 Country) 1 XM 2 F 53 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Baltimore Dundalk 1 Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21222 7990 St. Monica Drive 212 USA Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes White Yes, Give Year Specify: 1 Yes 2X No specify: 3 Widowed 4 Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Rusiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th N/A N/A N/A 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Mary Barker James Edward Sigmon, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 5602 Church Dr. Charleston, W.VA 25306 James, Sr. Mary Sigmon? Pare 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 Cremation 3 Removal from State Final Journey 5/13/10 Woodbine, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Charisse N. Woods F/S nature of Funeral S 2700 Edmondson Ave. Balto., MD 21223 . Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Modical Death Non ischemic cardiomyopathy Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical AMENDED 10f per fh g903 5-13-10 vt XUNPENDED ending physician use as the burial per ME g904 6/18/10 TT PII, The law requires that the death certificate be Box 68760, 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed Vital Records, certificate has been a 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes ŏ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Division 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of OOME May 11, 2010 O.C.M.E. Bei the of death (film 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed (Month, Registra

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15015 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elwood Junior Street Month 6:00 AM Mav 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2711 E. Biddle St. Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Mar. 18 9. Birthplace (State or Foreign **Funeral** Country) - V<u>irginia</u> 236-58-0453 Days 1**X**□ M 2 □ F Months Hours Min **Director** 77 1933 W Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD N/ABaltimore or 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2711 E. Biddle St. 23a 21213 USA items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

X Yes 2 \( \sum \) No Black, White, etc. 1 Never Married 2 Married 0 ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: "natural" Specify: Black 3 Widowed 4 Divorced Completed er than "natur ; the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within .
Department of Health and Mental Hygiene.
Important: If item 27 is marked other thar any injury or other traumatic event, the M Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Commissary Supervisor Amtrak Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ernest Spruiel Lena Street 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 E. Biddle St. Baltimore, MD 21213 Petula Caesar/ Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5 / 1 1 / 1 9ate 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 2 23a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ nenmon disease or condition day Medical resulting in death) (or as a consequence of) **Examiner** 3 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No Completed 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital. 2 No 은 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hudson street 21224 2801 Bairo. wonal mac الحا

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ton Sim  $\mathcal{T}_{\mathsf{Y}}$ VICH ZÖIO Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 10 170 liddie Ursing al Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Min. 935 NEW 1 X M 2 □ F Orleans Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show City, Town or Location 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State within 72 hours after death with the Maryland Funeral Director 1 Yes 2 No 110 9 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Middleway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Give Baltimore, Maryland 21215-0036 1 Tes 2 No Blac 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life\_DO NOT use retired) nt of Health and Mental Hygiene. t: If item 27 is marked other than ' or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) မ Sy SON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Ellezzie pson 20c. Location - City or, Town, State 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition Date or other place) Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Nationa 4 Donation 5 Other (Specify) 21. Signat e f Funeral Service Licenses 22. Name and Address of Facility BERTY 9190, tehts 0715 S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer nKnown Physician/ metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day ate has been signed by the atterpage 2 should be detached for u in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗋 No 3 🗍 Probably 4 🗖 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 0000 performed 2 XNo eral Director; After this certificate filled in by the funeral director, page 1 Yes 100 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 2 📉 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 5 Pending 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director; Af
completed filled in by the fu Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ZOIL MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD21236 enwo 31. Date filed (Month, Day, Year) 32. Regis rar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of I		d Mental Hy	/giene Reg. No.		15017
W.	Physic /Medi		Decedent's Name (First, Middle, I     Mary	ast) Eliza	abeth	Shaw		2. Date of D Month May	Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, g	ive street and numbe	er)	4b. City, Town,	or Location of De			ty of Death	-11.45 P
	Funeral Director		219-18-9363	Sex 7.	Age (In yrs. last birthday 83 Yrs.	Months Days		8. Date of B (Month, D) 0 7 / 1 6	irth (1926	Count	ace (State or Foreign (13) Land
	Maryland f show ied at	jo.	Usual Residence of Decedent  10a. State 10b. County  MD Baltim	nore Co.	10c. City, Town or L		on			10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the N a or 28a- be notifi	Funeral Director	10e. Street and Number			TOWS			10g. Citizen of		ry?
:	eath is 23g	eral	305 E. Joppa	Road Apt			286	(Specify Ven or N	U.S	· A .	an Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Force	s? 【 No	Was Decedent of If Yes, specify Cub		(Specify res of Nuerto Rican, etc.)	Speci	ack, White, e	etc.
15-0	"natur "natur edical l	leted	15. Decedent's (Specify only highest of	Education grade completed)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of	working	16b. Kind of E		
Maryland 21215-0036	ed withir giene. er than , the Me	Be Completed	12th Grade	College (1-4d	or 5+)		ru)		VA H	ospit	al
and	t be file antal Hy ed oth	Be (	17. Father's Name ( <i>First, Middle, La</i>	,	· • •			Name (First, Middle	_		
<u> </u>	should nd Me mark matic	은	Shepherd 19a. Informant's Name/Relationship		art	ing Address (Stree	Wilab		Hol ber. City or Town		Code)
<b>S</b>	und 2 s alth ar 27 is 27 is		Stephanie Jam						•		,
Baltimore,	Pages 1 antent of He		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□Removal from Sta	20h Place of Disn	osition (Name of ematory or other place Brown F	i	Date / 07/10	20c. Location Balti	- City or Tov	wn, State
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Lin	ensee /	pane 2	Name and Addr oseph H	ess of Eacility Brow Fulton	n Jr. F Ave.,B	uneral altimo	Home	21217
other time	hysician		23 art1. Enter the disease, or co shock, in heart failure. List on Immediate Cause (Final	ly one cause on each	sed the death. Do not en line.		-				Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Seps Due to (or	as a consequence of):						
di.	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or	as a consequence of):						
3760,	rate be executed hysician and the burial-transit	ical	that initiated events resulting in death) Last	cDue to (ord	as a consequence of):						
P.O. Box 68	ath certific titending p or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnand □ Other <i>(specify)</i> _	cy			ate of deliver	ry Day Year
<u>ა</u>	res tnat the de signed by the a be detached f	by Ph	Part II. Other significant conditions	contributing to death	n but not resulting in the u	underlying cause gi	ven in Part I.				e cause of death?
Soro	w requir been si should	eted									ably 4 Unknown
		Completed							opsy formed?	prior to con death?	osy findings available npletion of cause of 2 🛣 No
VITa	certificate harector, page	Be	25. Was case referred to medical examiner?	Hoonital				Death (Check only			
o o	rnys this cr ral dire	- To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 X Inpa		III OLI DON		g Home 5 Res			)
DIVISION OF	within 24 hours after death, within 24 hours after death, To the Funeral Director; After this certifics completely filled in by the funeral director; p	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on be 280 Place of	Day Year) Injury	M 1□	Yes 2□No		how injury occu		Route Number
בו ב	within 24 hours after To the Funeral Directory completely filled in by		29a. Certifier 1 ★ Certifying I	building,  Physician: To the be	etc. (Specify) st of my knowledge, dea	th occurred at the t	ime, date and p	City or To	own, State)	nanner as st	ated
on out	ule no lin 24 h the Fu	Medical	one)	aminer: On the basis and manner	s of examination and/or i	nvestigation, in my	opinion, death o	ccurred at the time	e, date and place	, and due to	the cause(s)
	P with P loo	Δ	29b. Signature and title of certifier	Sma	wo D	29c. Licen:	se number 20051347	,	29d. Date sign 5/13	ed (Month, E	Day, Year)
	UV		30. Name and address of person wh			ĺ	Carita	550. D-3	timas: "	מוע סו	204
ř	Sta	te	Cynthia Soriano 31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	s street;	purre	JJU; Bal	criiore l	ידר רוו.	2U <del>-1</del>
	Registr		MAY 132	010	un S. A	and					
DHMI	H 17 Rev 1/2	J01		-		IGINAL					

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AMEND ITEM#8perINF, G904, 6/11/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 7:06 PM Reginald Sherrill В. 2010 MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimoul Hospital of city Baltimole 5. Social Security Number 8. Date of Birthy 15/19479. Birthplace (State or Foreign (Month, Day, Vear) 5/19479. 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 ▼M 2 □ F Months Days Hours Director 212-46-3962 07 MD Usual Residence of Deced ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sheeil 1√2 Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21215 3711 West Cold Spring Lane U.S.A. 2 . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married à 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 Reginald 1 Yes 2 No Specify: Specify: Black "natural", 3 Wildowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene.
7 is marked other than "r Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Police Dept. 12th grade Radio Technician 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Andrew Sherrill <u> Marv Wilson</u> known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Antwan Roberson-Grandson 3610 Chapman Road, Randallstown Md 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Patient Memorial Park 5/16/2010 Woodlawn, Md 21. Signature of Faneral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ CIRRHOSIS disease or condition DAYS Medical resulting in death) Due to (or as a consequence of): Examiner DISEASE ALCOHOLIC LIVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine death certificate be executed HEPATIL ENCEPHALOPATH attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical PORTAL HYPERTENLION IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. Records, To the Hospital or Attending Physician: The law requires GASTROINTESTINAL BLEEDING ESD PHAGEAL 1 Yes 2 No 3 Probably 4 Unknown been ACUTE ON CHRONIL PENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 certificate 1 Yes a No 25. Was case referred to medical examiner? Division of Vital funeral director. 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work death. Accident
Suicide 1 ☐ Yes 2 ☐ No after death Director: A I in by the fi Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours after Funeral Dire leted filled in b Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Funer

completed file 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Mal AMIT BHISE MBBS REG-000 MAY-10-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, OF BALTIMORE BHISE HOSPITAL MD-21215 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year Day May Physician/ Harold Richard Selby 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 422 Ouaker Hill Road Union Bridge Carroll If Under 1 Year If Under 24 Hrs. . Social Security Number 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) Funeral Nov. 13, 1925 1 X M 2 T F Maryland 220-18-2492 Director 84 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director event, the Medical Examiner must be notified MD Carroll 1 X Yes 2 No Union Bridge 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 422 Ouaker Hill Road 21791 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 1943-46 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 Maintenance supervisor Cement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Raymond Earl Selby, Sr. Mildred Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Jane G. Selby - wife 422 Quaker Hill Road, Union Bridge, MD 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State injury or 4 Danation 5 Other (Specify) All County Cremation 5/9/2010 Sykesville, MD 21. Si na re of Funeral Service Lic Hartzler Funeral Home Union Bridge. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 😾 No <u>۾</u> 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Hame 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pendina s after death.

al Director: Af 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0020330 May 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Lehigh 104 N. Main St. Union Bridge, MD 21791 32. Registrar's signatur 31, Date State Registrar

DHMH 17 Rev 7/2009

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		-	For State	State of M	/larylan		ırtmen <i>tificate</i>			and Me			2010	150	20
		-	Registrar  1. Decedent's Name (First, Middle, Las	t)			imodic	0, 0	- Cutti	- 2	2. Date of Dea	Reg. No. ath		3. Time of D	)eath
	Physicia Medic		JAMES							Month Day Year			0304	М	
	Examin		4a. Facility Name (if not institution, give						Location o	of Death		4c.	County of Death		
			Suburban Hospita				Beth			0411			ontgomer		
- 1	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex ⊠M2□F	.ge (In yrs. Ia	ast birthday) Yrs.	If Under Months	Days	If Under	Min.	3. Date of Birt (Month, Date 12	th y, Year) 1 C	9. Birth Cour	place (State or htry) NC	Foreign
			Usual Residence of Decedent				1				141.	., 1	2-7		
	/land f sho d at	tor	10a. State 10b. County		10c. Çit	y, Town or Loc	ation							10d. Inside City	
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	th the	Funeral Director	10e. Street and Number				10f. Zip						zen of What Cou	ntry?	
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(0	or ite	by Fı	<ul><li>11. Marital Status</li><li>1 X Never Married 2 ☐ Married</li></ul>	Armed Forces'	?	5.   13. V	Yes, spec	fy Cuban	, Mexican	, Puerto Rio	y Yes or No- can, etc.)		Black, White,		
93	rs afte iral", Exar	edt	3 Widowed 4 Divorced	1 🛛 Yes 2 If Yes, Give ] Year or Dates.	- 1945 194	- 7   1	☐ Yes 2	∑ No	Specify:				Specify: B1	ack	
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2	d wit Hygie rther nt, th	Be C	12th  17. Father's Name (First, Middle, Last)			Rigge	<u> </u>		10 M-45-		First, Middle,	<u> </u>		Cii Ceiii	
an	be file	일	Simmon Speller							ter Co		Maidell	urriarrie)		
Σ	ould Me		19a. Informant's Name/Relationship (7)	rpe, Print)		19b. Mailin	a Address	(Street ar				r. City or	Town, State, Zip	Code)	
Ξ	d2stathaattha		Beverly Smith - 1	Niece			-						MD. 2070		
J.	of He fitem		20a. Method of Disposition			Place of Dispos	sition (Nam	e of her place	2)	Dat	te	20c. Lo	cation - City or T	own, State	
<u> </u>	Page ment ant: I		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			Linco				5-7-20	010	Bre	ntwood,	MD.	
┼ Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	a Uha	W	) 22 M. 4	Name and arsha 308 S	TI S uit1	s of Facility Fund and I	ěral I Rd.	Home o Suitla	f Ma	ryland, Md. 2074	Inc.	
20			23a. Part 1. Enter the disease, or my shock, or heart failure. List only o	olications that cause	ed the death									Approximate Interval Betw	
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Box	e dear the at hed fo	Physician/Me	1 Yes 2 No	4 ☐ Pregnant 9 ☐ Unknown		death 5 □	Other (sp	ecify)					Month	Day Ye	ear
P.O.	at the	/ Ph	Part II. Other significant conditions co	ontributing to death	but not res	ulting in the ur	nderlying c	ause give	en in Part I		23e. Did to	obacco u	se contribute to t	he cause of de	ath?
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4 6	ing P	ate:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of inj (Month, Da	jury ay, Year)	28b. Time of injury		c. Injury work?			d. Describe h	now injury	occurred		
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al a	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	sician: To the best of											ner stated
10	the H thin 24 the F mplet	Me	only one) 3 - Certifying Num	e Practioner To the	e best of my	knowledge, id	eath undur	ad at the	time data	and place.	erid due to the	e rauselu	all all mall ner ac c	hated	
07	S 7 ≰ <b>5</b>		29b. Signature and title of certifier					License		4			e signed (Month,		
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	3 <sup>x1</sup>		20. Dame and address of person who of	Kathistein	death (Item	1 ZSaj (Type, Pi	:00 /	0/1	Genr	ar tour	N Pol	Do	13/2 Hhesda,	MdZO	814
36	Stat	100	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ture	1						1	-	
	Registra	ir	MAY 13 2010	Cener	D. 1	garke									

State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ MM Spth 20 Ye 8:15 P M Theresa Scharpf Anna Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Lutherville Hearthomes Assisted Living g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours April 1 Day 2 3 1929 Maryland 1 □ M 2 🛱 F 220-20-4360 81 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 X No Baltimore Dunda1k faryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21222 U.S.A 543 Larkfield Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Þ 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NA Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ္ပ္ Jerzak Dimitric Pogash Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 i 607 Harvest Court Bel Air, Maryland 21014 Richard Scharpf (Son) Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition May 94,2010 permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory Inc Signature of Funeral Service Licens 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. Baltimore, Maryland 21224 1005 Dundalk Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death infaction Immediate Cause (Final In conderc Physician/ disease or condition resulting in death) nus Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, Examir burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Medical P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery Physician/ 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death been signed by the should be detached 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death. Funeral Director: After this certificate has b autopsy , page 2 1 Yes 2 No After this certificate 26. Place of Death (Check only one) **Division of Vital** funeral director, 25. Was case referred to medical Be examiner? Ssistentic Other: 4 Nursing Home 5 Residence 6 Other (S) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Directors,
completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle o L-46) and address of person who completed cause of death (trem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M G 4 nora Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 DICP WSO 4 (9) Year If Under 24 Hrs. 8. Date of Birth (Month, Day 7. Age (In rs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours 6 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State Director IMOVR 1 1 No 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 Funeral Jabash 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Yes 2 No ğ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: aC If Yes Give Specify 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry 08 (Specify only highest grade completed) DIVISON and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) role dminstrative 1455 Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Mjddle, Last) ဂ္ eene ross be VU inia permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic ange. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3649 MO Jaloash Acua erina tevenson Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Owing Mills, Md 5-19-2010 TuresT Sarrison 22. Name and Address of Facility Furene 21. Si viature of Funeral Service Licensee Ba ITO M LBERTY Rts 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Danc Physician/ reation disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 X No has within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5  $\square$  Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Registrar' Signature State arke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:45A M <u>Dorothy Adline</u> Tudor May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7851 Birmingham Avenue Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 🗆 M 2 😾 F Months Days Hours Min. **Director** 219-18-2483 1926 Baltimore, Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXVo Maryland Baltimore Parkville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7851 Birmingham Avenue 21234 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 XXIIII Maryland 21215-0036 Mental Hygiene. 1 ☐ Yes 2 ☐XNo Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home 10 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Edward Riedel Emma Andrae Groscup . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Baraloto -Daughter 2801 Coldstream Way Apt. C Baltimore, Maryland 21234 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State More land Memorial Park Parkville, Maryland 4 Donation 5 Other (Specify) May 13, 2010 Signature of Funeral Service Licenses 22\_Name and Address of Facility Evans Fureral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line.

Immediate Cause (Mal Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Year 1 Yes 2 No Pregnant at time of death Month Day 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be o CHE Previous strokes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? disease 24a. Was an Jas performed? After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director; 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0051926 MUD 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Charles St- PPE 203

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH. G903.5/21/2010.WS
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** William Gilbert Thomas Month Vear may 0836 am 2010 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner saltimore Hospita (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept. 4, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number **Funeral** , Year) 1928 Days Hours 1 🖾 M 2 🗆 F Sept. Massachusetts Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Arbutus 1 □Yes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21227 Funeral 1229 North Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: 14. Race - American Indian, 11. Marital Status Black, White, etc. White 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Wait Tables Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Elgin Thomas Constance Trudeau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1229\ North\ Ave.\ Arbutus,\ MD.\ 21227$ 19a. Informant's Name/Relationship (Type. Print) Michael Shutt, son-in-law 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 05 - 10 - 2010Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 234 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardio vascular Disease Htherosclerotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its land as a control of the cause of the cau Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00058141 May 7, 2010 eller mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S . Caton Avenue 900 Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Thomas,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			I- For State Registrar	or waryland / Di	Certificate of		ia ivientai i		g. No. 20	110 1502		
	Physici I Exami		Decedent's Name (First, Middle,Last     Kellie Taylor		· · · · · · · · · · · · · · · · · · ·			2. Date of Death Month May 11, 20	Day Year	3. Time of Death 0630 hrs		
	}		4a. Facility Name (if not institution, give		4		or Location of Death		4c. County of D	Death		
	Funeral	4	706 Rambo Court Halethorpe  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24						Baltimore (	County  Birthplace (State or Foreign)		
	Director		216-06-4726	M 2XF 26	ys Hours Mir		6, 1983	Country) Korea				
	any	ŀ	Usual Residence of Decedent  10a, State  10b. County	10c.	City, Town or Location	on		"		10d. Inside City Limits		
	Maryland 28a-f show 1 at once	ĕ	MD Baltimo	re H	alethorpe					1 Yes 2 No		
	eath with the Maryland items 23a or 28a-f sho ust be notified at once	Director	10e. Street and Number 706 Rambo Court	ri .		10f. Zip Code	227	10	Og Citizen of What USA	Country?		
•	filed within 72 hours after death with the Maryland Hygiene, Hygiene, d other than "natural", or items 23a or 28a-f she t, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 Yes 2 X	No If Ye	es, specify Cuba	lispanic Origin? ( S an, Mexican, Puerto		14. Race - A White, e Specify: A			
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93	iled within Hygiene. I other the the Med	mo.	17. Father's Name (First, Middle, Last)	4	Enviro	пшепса.	18.Mother's Name	e (First. Middle. N		Housing Development		
21215-0036	ould be filed within 72 hou Mental Hygiene, marked other than "nat ic event, the Medical Exa	Be	Stephen Loverde Terri						,			
MD 21	Pages 1 and 2 should ment of Health and Me ant: If item 27 is ma or other traumatic er	٤	19a Informant's Name/Relationship (Ty Michael Taylor	Husband	706 I	Rambo Co	ourt; Hal	ethorpe	ber, City or Town, MD 2122	7		
Baltimore,	iges lan it of Hea i: If iter other tra		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from State	20b. Place of Disposi crematory or oth Atlantic (	er place)		Date 5/2010	20c. Location - Ci			
altin	permit. Pages I Department of F Important: If injury or other		Donation 5 Other Specify:  21. Signature of uneral ervice Liper	2 2/	22. N	ame and Addre	ss of Facility 5 t e	rling As	shton Sch	wab Witzke		
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		iner	if any, leading to immediate cause Enter Underlying Cause	Due to (or as a conseque	nce of):							
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Box 687	eath certific e attending for use as t	Physician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	of death	al death 3	Ectopic pregn	ancy	Month	Day Year		
Bô	the atte	hysi	1 Yes 2 No 9 V Unknown	1 9 OUKHOWH								
P.O.	ending Physician: The law requires that the death certificate be executed at the this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - trans	ρ	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause	e given in Part I			Interto the cause of death?  Probably 4 Unknown		
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ecol	he law ate has age 2 sh	dwo						autop perfor	med? dea	or to completion of cause of ath?  Yes 2 X No		
<u> </u>	ysician: The law his certificate has director, page 2 sl	Be C	25. Was case referred to medical examiner?			26.Pla	ce of Death (Check			3		
Ž	Physic er this rat dire	입	1 ✓ Yes 2 No  27. Manner of Death	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of I		Other Nursi		Residence 6 🗸			
<i>)</i> Division of Vital Records,	- 0 5 -	Certification:	1 Natural 5 Pending 2 Accident Investigation	FOUND: Day, Year) on May 11, 2010	FOUND: 0620 hrs	1	Yes 2 No	Subject place inhaled hydi	ced plastic bag rocarbons	over head and		
Divis	pital or At ours after d eral Direct filled in by	ertific	3 ✓ Suicide 6 Could not determined	be	- At home, farm, stree Family Home	et, factory, office	building, etc.		Street and Number ( state) t., Halethorpe, M	or Rural Route Number, City		
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only 1 Certifying Physici	an: To the best of my kno	owledge, death occur			d due to the caus	se(s) and manner as	s stated.		
and manner stated.  29b. Signalure and title of certifier  29c. License number									29d Date signed	(Month, Day, Year)		
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	0		30. Name and address of person who clared Locke MD. Assist	completed cause of death		Street, Balt	timore, MD 21	201				
		tate	31. Date filed (Month, Day, Year)	32. Registrar's		, = -						
	Regis	trar	MAY 13 2010	person p.	7							

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 6 n550 2010 **Physician** Wolf Frederick Leonard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2□ F 216-16-0934 Nov. 5, 1921 Maryland Director 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show items 23a or 28a-f shov Forest Hill Harford 1 ☐ Yes 2 X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21050 USA 2286 Phillips Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 X Married 7 is marked other than "natural", or i traumatic event, the Medical Evanir 1 ☐Yes 2 X No Specify: Specify: \$ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lineworker Auto Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Robert Wolf Anna Hoeful ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 is Mary Collins-daughter 2286 Phillips Mill Road-Forest Hill, Maryland 21050 Department of Health Important: If Item 27 any injury or other the ODICE. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel May 10,2010 Bel Air Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services Belair 3 Newport Drive-Forest Hill, Maryland tadd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracranial Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner weeks Cerebravascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ned by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🛣 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.0. Division of Vital Records,

law requires that the death certificate be executed e Hospital or Attending P 24 hours after death. P Funeral Director; After t filled in by the 24 hours a To the within 2.

death

should be filed within 72 hours after

Pages 1

altimore, Maryland 21215-0036

111 State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathryn Novello Silva 22 S. 31. Date filed (Month, Day, Year)

32. Registar's Signature



1🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Greene St. Balto. Md 21201

D61653

29d. Date signed (Month, Day, Year)

May 12, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03345 State of Maryland / Department of Health and Mental Hygiene Lloyd Andrew Welch Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Da May 1, 2010 0046 hrs **Medical Examiner** Lloyd Andrew Welch

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Baltimore County** Halethorpe 3648 Washington Boulevard 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number Funeral Months Days Hours Director March 5,1955 Maryland 215-64-2990 1X M 2 F 55 Yrs Usual Residence of Decedent 10d. Inside City Limits Oc City Town or Location 10a State 10b. County X Yes 2 No Baltimore MD N/A Show notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21229 113 Allendale St. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes White 1 Yes 2 X No specify: Specify: Divorced f Yes. Give Year Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) N/A d other than ", the Medical I N/A Disabled 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ann Dye Mary Clarence We 1ch Edward Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 3632 MacTavish Ave. Baltimore, MD. 21229 Ashby/ Sister Deborah Department of Health ar Important: If item 27 injury or other traums 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05-05-2010 | Odenton, MD Atlantic Crematory Donation 5 Other Specify. 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21 Promise of Funeral Service Licensee 1328 Sulphur Spring RD. Arbutus, MD. 21227 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Narcotic intoxication Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last requires that the death certificate be executed Physician/Medical X UNPENDED attending physician a AMENDED 23a 27,28a-f,per ME G903 5.14.10 TT Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy IF FFMALE 23b. Was decedent pregnant in the Year Month Dav 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ģ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed Yes 2 ✔ No 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 ✓ Yes 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Yes 2X No Natural Pending 24 hours after death. Funeral Director: the /1/2010 Accident Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State 3648 Washington Blvd Halethorpe, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined mote1 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 펺 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) May 2, 2010 O.C.M.E. ne and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year Registrar

DHMH 17 Rev 1/2001

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 6, 10:09 P M 2010 May Bertha B. Wilson 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Genesis Eldercare Long Green Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number 6 Sex Hours Months Days 1 □ M 2 🔀 F 2. 1913 Maryland Oct. 96 213-32-2830 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21212 115 E. Melrose Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White WWII 1 □Yes 2 1XtNo Specify 3 ₺ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) White Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Mielke John Baer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1707 Berdan Court; Belair, MD 21015 Anna Buscemi Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD Ward's Chapel Cemetery 5/12/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Ligensee m01050 ٤ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLENOTIC CARDIOVASCULAR DISEASE Immediate Cause (Final Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If ves. outcome of pregnancy 23d. Date of delivery 3 Fctopic pregnancy Year Live birth 2 Fetal death Month Day 5 ☐ Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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other traumatic event, the Mudical

Director

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Baltimore, Maryland 21215-0036

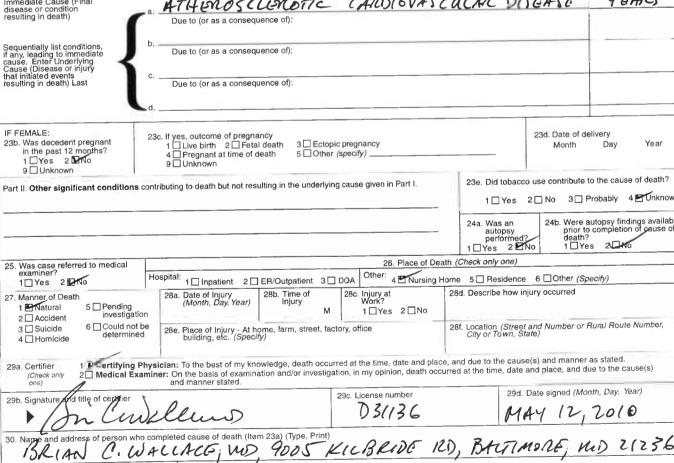
attending physician and P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifies Son

Division of Vital Records,

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32. Registrar's Signature

OHMH 17 Flev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Denne S. fares OFICHIVAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2ďib 0206 SIMON WILSON SR. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours Min. July 9, <sup>Y</sup> 1923 86 Director 239-32-8723 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4025 E St. SE 20019 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N Yes, Give Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 mound Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur matur." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GSA Supervisor 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Fannie Faison Frank Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germantown, MD. 20875 12536 Timber Hollow Pl. Simon Wilson, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State 5-15-2010 Suitland, MD. Lincoln Memorial 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee Marshall s Funeral Home of Maryland, Inc. Suitland Rd. Suitland, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final liente wharch Ph sician/ disease or condition resulting in death) Medical Due to (or as a cons tueno **Examiner** Sequentially list conditions. Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due lu fur da a conseu as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Po Month Day Year Pregnant at time of death signed by the a g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 🗌 Yes 2 NO Yes 25. Was case referred to medical examiner?

1 2 Yes 2 1 No Division of Vital 26. Place of Death (Check only one) funeral director, Be Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cepting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number D0055120 7 2010 vul 841 and address of person who completed cause of death (Item 23a) (Type, Print) Just 310

Registrar DHMH 17 Rev 7/2009

State

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MD

32. Registrar's Signature

Varmi

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Pay Physician/ 2010 02:33 a M DEXTER WEAVER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Jan. 14, Days Hours Country) 1 🕱 M 2 🗆 F NC 57 578-70-3908 Director Jsual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 ☐ Yes 2🏗 No Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Examiner must be Funeral 23a within 72 hours after death with USA 7126 Marbury Ct. 20747 items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ō ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Specify: Black "natural", 3 Divorced 4 Divorced Completed than "natura th∗ Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene ą. Self Employed 12th Handy Man is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Mildred Jones Richmond Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. District Heights, MD. 20747 7126 Marbury Ct. Brent Weaver-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-14-2010 Suitland, MD. Hill Cemtery 22. Name and Address of Facility
Marshall's Funeral Home of Maryland, Inc.
4308 Suitland Rd. Suitland, MD. 20746 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Shock the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical liver Disease Alchoholic Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No should be detached g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 2 No certificate 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28a. Date of injury 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 V Natural 5 Pending work 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065729 05/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 ARZAD MALEKANIAN MO 7503 SURRATTI ROAD CLINTON MP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For Amend Item Registrar	s 25,27,28a	-f pe	er me	g903.0 Tilicate	5/13/2	2010dh	b	Reg. N	.201	0 150	31	
	Physicia	n/	1. Decedent's Name (First, Middle, L	.ast)						2. Date of De Month May		ay Year	3. Time of Dea 9:00 P		
	Medic	al	Merle Nelson Young  4a. Facility Name (if not institution, g		4h City Toy	un or Locati	ion of Death	Мау		c. County of De		IVI			
	Examin	er	Glen Burnie Health		Burnie				Anne Arun						
	Funeral		Social Security Number 6.	st birthday)	If Under 1 \	ear If Un	ider 24 Hrs.	8. Date of Bir	th	9. B	irthplace (State or For	reign			
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	nd how at	'n	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10										10d. Inside City Lie	mits	
	laryla 3a-f s iffied	Director	MD Anne Arundel Clen Burnie										1 ☐ Yes 2x	X No	
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	death r item ner n		11. Marital Status	12. Was Decedent E Armed Forces?			Vas Decedent f Yes, specify	of Hispanic Cuban, Mex	: Origin? (Spe tican, Puerto	ecify Yes or No- Rican, etc.)			Race - American Indian, Black, White, etc.		
336	al", o	d by	1 ☐ Never Married 2 ☐ Married  3XX Widowed 4 ☐ Divorced	d 1XX Yes 2 ☐ If Yes, Give Year or Dates.	1951	1	☐ Yes 2 X	No Spe	cify:			Specify:Whi	te		
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21215-0036	nin 72 ne. han " e Mec	Completed	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DO	kind of work do NOT use ret		nost of work	ng			0 1		
72	d with	Be C	17. Father's Name (First, Middle, Las	4)		Steel	Fitter	T 40 M	lether's News	e (First, Middle,		/is Steel	& Lumber		
Maryland	be file antal F ked o c eve	70 E	James Young	y .						Irene Di		Surname)			
ary.	nould nd Me s mari	1	19a, Informant's Name/Relationship	(Type, Print)		19b. Mailin	ig Address (St					r Town, State, 2	Zip Code)		
	d2shaaltha altha 127is ertra		Richard A. Young	Son		7506 0	old Stag	e Rd.,	Glen Bu	rnie, MD	2106	51			
ore	of He of He If item		20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3	Removal from State			sition (Name o		ı	Date	20c. L	_ocation - City o	or Town, State		
<u>H</u>	. Page tment tant: I		4 Donation 5 Other (Spe	cify	Mea		ge Mem. I		May 7,		Elkr	ridge, MD			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign and of Funeral Service Lic- K. Gregory Fink		_	22	Name and A Fink Fu 426 Cra			A. n Burnie	. MD	21061		3	
П				polications that caused		. Do not ente							Approximate Interval Between	n	
Samuel .	Physician/	N N	Immediate Gause (Final disease or chidition ACIRATION REUMANA ATTACHMENT ACIRATION REUMANA ATTACHMENT ACIRATION ACIRATION REUMANA												
	Medical Examiner		resulting in de	Due to (or as a	consequence of):					con	10 45			2 0	
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	pot!	RAZIZED ARRIGHE				25Ce Quic 15-4/6			300			
	execuran and ial-tra	Ex	that initiated events resulting in death) Last	Due to (or as a	i conseque			15-7	$\overline{\cap}$		renical	EXAMINER		3	
1,00	cate be executed physician and the burial-transit	Medical		d				—-с	ERTIFICATION	APPROVED BY	MEDION				
687	rtifical ing ph e as th	/We	IF FEMALE:	00-16				<u>_</u>							
X	ath ce attend for us	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live Birth 1 ☐ Pregnant at	2 🗌 Fetal	death 3 [	Ectopic preg					23d. Date of d Month			
P.O. Box	y the c	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9  Unknown	11110 01 00	Julii 0	- Carior Jopeson	"							
P.0	that the	by P	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.  HH FRACOVEE  1 LING CANCEL					Part I.	23e. Did to	obacco	use contribute	to the cause of death'	?	
ds,	quires en sig	led t	R1647 1	411 HD3	COU					1 🗆	Yes 2	□ No 3 🖔	Probably 4 🗌 Unkr	iown	
Sor	aw rec as bee 2 sho	Completed	HISTORY	LUNG	CAn	Ull				24a. Was		prior to	utopsy findings availa completion of cause	able of	
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Ž	Phys	<u>د</u>	1 1 Yes 2 2 1 No 27. Manner of Death	1 Inpatie	v 2	R/Outpatien 28b, Time of		Injury at		me 5 🗌 Resid 28d. Describe h		6 ☐ Other (Spe	cify)		
o uc	ath. : After	cate	1 Natural 5 ☐ Pending 2 AccidentInvestigat	(Month, Day,		injury U <b>nknow</b>		work? 1 🗆 Yes 2	_	Subjec	-	•			
Division of Vital Records,	r Atter ter des rector	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Injur	ry - At hom	ne, farm, stre	et, factory, off	fice		28f. Location (S	Street an	nd Number or R	ural Route Number, Furnace urnie,MD		
á	oital o			Nursing	Home										
A	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check 2 Medical Exa	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	camination a	and/or investi	igation, in my o	pinion, deat	h occurred at	the time, date a	nd place	e, and due to the	cause(s) and manner	stated.	
7	Voith com		29b. Signature and title of certifier	200			29c. Lic	cense numb	er 7 6 0 9	7	29d. Da	ate signed (Mon	th, Day, Year)		
	4			1-1/2	oth //t	32a) /T		V 6	2601			1119 4	- 2010		
	`		30. Name and address of person who	860GR	M-1			TRNA	UE BI	Anch	Ro	Gent	th, Day, Year) - 2010  Swill Mal Zi	Кe	
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registra	r s Signatu	ba	Med								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) aa **Physician** Apri 1 2010 Elizabeth L. Adkins /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ncessanne comerse Manokin manor Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number **Funeral** Min 1 □ M 2 🔀 F Yrs. 403-28-5035 96 Nov. 5, 1913 Delaware Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f shov 1X Yes 2 □ No Director Princess Anne MD Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21853 U.S.A. 11974 Edgehill Terrace items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗷 No Specify: white ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contractor 12 Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lenora Polight Baxter LeCates ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21804 31692 Dilworth Avenue Salisbury, MD of Health (Daughter) Eleanor Rebert other Department of Heal Important: If item 2 any injury or other once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 04-26-2010 Delmar Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee Short Delmar, DE 19940 13 East Grove Street Vew 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No been signed by the should be detached 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☑No director. 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4123/10 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 21804 3 mp shere 54453URy

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amended #28c pertater of Maryland / Department of Health and Mental Hygiene Registrate mended #8 per FH, RG FCHD 4/30 ertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Year APRIL 20 Day :58P Physician/ ABBOTT JAMES DAVID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeal) 947 **Funeral** Days Hours Min Washington, DC 62 577-64-7943 **Director** Sent Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland 10a. State Director 1 Yes AND No Walkersville Frederick <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States "natural", or items 23a Funeral 21793 9001 Grape Creek Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Education Teacher +5 traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed. Department of Health and Mental Hilmportant: If item 27 is marked ott any injury or other traumatic even ပ Joan Janezeck William Abbott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9001 Grape Creek Drive, Walkersville, MD 21793 Cynthia Abbott / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Tremation 3 Removal from State Frederick, Maryland 4/26/2010 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home Signa are of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD Ratu. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ Renal Failure Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury Mellitus Diabetes sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Year in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death the Unknown g 🗌 Unknown P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed h þ 1 Tes 2 X No 3 Probably 4 Unknown Division of Vital Records, The law requires Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛛 No Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: ✓ Natural injury 5 Pending 1 Tyes M Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check з 🗌 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat April 26, 2010 D0035267 pro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 400 W 7th St. Frederick, Md. A Casiano Manuel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 158.30

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** JOAN H. AHLBORN 3:10 PM April 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare -The Pines Easton 8. Date of Birth (Month, Day, Year) 04/01/1930 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1□M 2**X**F 80 PA 190-24-0832 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygleine. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises and the notitied of once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐Yes 2X No Director ROYAL OAK **TALBOT** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21662 6815 THORNETON ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐Yes 2 X If Yes, Give Ye ar or Dates: 1 ☐ Never Married 2 X Married 2 **X**No oan Ahlborn Itimore, Maryland 21215-0036 1 □Yes 2X No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY RELIHAN HENRY HASTINGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6815 THORNETON RD., ROYAL OAK, MD WILLIAM AHLBORN/HUSBAND Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 04/27/2010 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nonth **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ed by the a detached f P.O. I 9 | Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 22No autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?

1 ☐ Yes No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

MICHAEL 31. Date filed (Month, Day, Year) APR 2

29b. Signature and title of certifier

610

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(ROWLEY

DUTCHMANS

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 2010 6:25 P M Physician/ Brown Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Upper Marlboro 14715 Dunbarton Dr. 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number (Month, Day, Wheeling. Funeral Months Days Hours 1 ☐ M 2 🗓 F 88 201-10-8540 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State **Funeral Director** 1 ☐ Yes 2 X No Upper Marlboro Prince George's 10g. Citizen of What Country? 10e. Street and Numbe ò permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a i amy njuny or other traumatic event, the Medical Examiner must be once. US 20772 14715 Dunbarton Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?, 1 Yes 2 No If Yes, Give 11. Marital Status Black White, etc. 1 Never Married 2 X Married þ white 1 Yes 2 X No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evalyn L. Meyers ည Arthur W. Frazer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Upper Marlboro, MD 20772 14715 Dunbarton Dr. James L. Brown 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 5/6/2010 Cascade, MD Bethel Church Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 21. Signature of Funeral Service Lice Waynesboro, PA 50 S. Broad St. 23a. P of 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition dranced Sanile Rhysician/ Medical resulting in death) Many yos. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day in the past 12 months? 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease, Atrial Fibrillation 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? Rheumatoid Arthritis, Hypothyroidism 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Investigation
6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide
4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie 14/2010 1001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Green way Cnyr.

Stuart J- Turkewitz, MD. Green bell, MD 2077

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 4:00 P M Byler Ellen Mary 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 27588 Woodburn Hill Road Mechanicsville 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) July 19, 2002 Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 🗌 M 2 🔀 F Maryland 7 Yrs. Director unknown Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f showevent, the Me lical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🗓 No Mechanicsville St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20659 USA 27588 Woodburn Hill Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 X Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary School permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thin any injury or other two. Student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Naomi S. Hertzler Jonathan M. Byler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27588 Woodburn Hill Road, Mechanicsville, MD 20659 Jonathan M. Byler / father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 28,2010 Hertzler Cemetery Mecahnicsville, Maryland 4 Donation 5 Other (Specify) 21. Si mat ir of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Fuenral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardia Arren 4/20 resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a conse len e of): the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be east hours after death.
Puneral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3. Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) signed by the a 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é 2 XV0 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No 1 🗌 Yes 2 🗎 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 🔲 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 wllor 2829 4-26-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 -2-811 Washin

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a per phys. G904 6/2/10 dk

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 26, 2010 10:15 PM BRATCHER, JR. April WESLEY JAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset Crisfield McCready Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 ☑ M 2 □ F 216-76-3558 50 04/29/1959 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Crisfield 1 ☑ Yes 2 ☐ No Maryland Somerset "natural", or items 23a or 28a-f sk idical Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21817 133 Richardson Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Waterfowl Wood Carver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ges 1 and 2 should be fit of Health and Mental Hit item 27 is marked ot Leona English James Wesley Bratcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 133 Richardson Avenue - Crisfield, MD 21817 Lori Bratcher (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any Injury or \* 5/3/2010 Echols, Kentucky Echols Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility H once. Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATIC METASTATIC CANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2X No certificate 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 🗌 Yes 1 npatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 17 Natural 28b. Time of 28c. Injury at Work? After t 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. al or Attendi s after death. 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or Viay Kaumbu nathan 20 Heill Highway, MD 21817 (nisticles 201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0435 Physician/ iAM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H'NAN If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7, Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Manth Po; 1 □ **x**M 2 □ F Months Days Hours Min. <sup>Year</sup> 956 Country) 218-64-3369 54 Yrs. Director Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland at Hygiene. 3 other than "natural", or items 23a or 28a-f sho 10a, State Funeral Director Cumberland MD Allegany 1 Xes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe must be 21502 USA 1012 Country Club Rd. Cottage C 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or item edical Examiner n 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Giv 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 white Completed 3 Widowed 4 Divorced Year or Dates . Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natu lury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) disabled n/a Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Dr. William Henry Carr, Sr. Chatta (Ingrom) Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 West Main Street Emmittsburg MD 21727 19a. Informant's Name/Relationship (Type, Print) Dr. William Carr Sr. father 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 5/6/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Scarpelli Frill Yeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between tolymph makes, liver, and Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No ò Year Day Pregnant at time of death ate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform Yes 2 No certificate 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital Other: 2 X No 1 🗌 Yes 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the Hosp within 24 hou To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00304 you, Não

State Registrar

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

INDA deHOYOSM.

Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April <sup>Day</sup> 2010 Physician/ 27 12:35 AM Cockerham Helen E. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 10, 1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Months Hours 1 M 2 TX 89 Feb Texas Director 445–14–4193 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 屎 No Maryland Adelphi Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 20783 United States 10110 Phoebe Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a, Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fin f Health and Mental item 27 is marked ည Tommie Strickland Konkle Vernon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward H. Cockerham/husband 10110 Phoebe Lane Adelphi, Maryland 20783 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Termation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/29/2010 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Licensee stinou M00957 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anoxic Encepalopathy Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Veal 5 Other (specify) Pregnant at time of death ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 Pending injury X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MD 063639 April 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Forest Glen Road Silver Spring, Maryland 20910 M.D. 1500 Pothu Raju Nagabhru 32. Registrar's Signature 31. Date filed (Month State recorde Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 1:00P <sup>M</sup> APRII 2010 WILLIAM CECIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT 29414 HOWELL POINT ROAD TRAPPE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 0/18/1942 Min. 1**▼** M 2 □ F Director MARYLAND 67 <u> 215–38–1482</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD TALBOT TRAPPE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral <u>29414 HOWELL POINT ROAD</u> 21673 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify. "natural", 3 Divorced 4 Divorced Completed WHITE Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ORETTA CONSTANCE DYOTT WILLIAM HENRY CECIL. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN JOSEPHINE CECIL/WIFE 29414 HOWELL POINT ROAD, TRAPPE, MD 21673 Page 1 and 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place, 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 04/28/2010 TRAPPE, MARYLAND WHITEMARSH CEMETERY Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1eav disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FFMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 D Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death ed by the a detached t Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No Hospital or Attending Physician; The law requires 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed certificate I 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of Certifying Nurse 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 DRIVE

STE, 301, EASTON, MD 21601

SMITH.

APR 26 2010

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TEAL.

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar FH. TCHD, 4/23/10, rls Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 6:20  $\mathbf{P}$  M JANE E. CHAPMAN 04 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **TALBOT** 25001 BACK CREEK DRIVE ST. MICHAELS If Under 1 Year If Under 24 Hrs. 8. Date of Birth 8/18/48 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min. 0871671548 1 M 2 X F KY 61 220-42-0666 Director Usual Residence of Decedent 10d. Inside City Limits shov 10c. City, Town or Location 10a. State 10b. County the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No TALBOT ST. MICHAELS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 72 hours after death with 21663 25001 BACK CREEK DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates is marked other than "natu aumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) **FEDERAL** College (1-4 or 5+) Elementary/Seconday (0-12) ADMINISTRATIVE ASSISTANT GOVERNMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file ည ERVIN ROTHENBUHLER BETTY JAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 st ment of Health a tant: If item 27 is 25001 BACK CREEK DR., ST. MICHAELS, MD ROBERT J. CHAPMAN/HUSBAND 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Date permit. Page 1
Department of I
Important: If it
any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State OXFORD CEMETERY 04/26/2010 OXFORD, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN R MERLERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician. BREAST disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last burial physician s the burial Physician/Medical requires that the death certificate be Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No atter for u Day Pregnant at time of death g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has 1 ☐ Yes 2 ☐ No Yes certificate Hospital or Attending Physician: 26. Place of Death (Check only one) Division of Vital Be 25. Was case referred to medica examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Vatural 5 Pending 1 ☐ Yes 2 ☐ No. M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after death

To the Funeral Director:
completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and le of certifie 29c. License number D39887 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 8221 TEAL DR., STE. 301, EASTON, MD DAVID H. SMITH, MD strar's Signature 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RALPH MORGAN COMINGS PRIL 2010 1:16 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT 102 WILLOWS AVE OXFORD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 046-34-8468 1 **X** M 2 □ F 65 Vrs CONNECTICUT Director 06/11/1944 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State Director 1 🗆 Yes 2 No **TALBOT** OXFORD MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 102 WILLOWS AVE 21654 U.S.A. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 No 1 ☐ Yes 2 No Specify Specify. 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICIAN MAINTENANCE 12 -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BETTY MAY THOMS RALPH MORGAN COMINGS, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 KATES POINT, TRAPPE, 21673 JAMES WRIGHTSON/EXECUTOR 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/26/2010 STEVENSVILLE, MD CHESAPEAKE CREMATION 22. Name and Address of Facility Signature of Euneral Service Ligenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examin burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IE EEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for ( in the past 12 months? Month Year Day Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death? this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

State Registrar

the Hospital

Medical

29a. Certifier

only one)

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

strar's Signature

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 18, FH, TCHD, 4/27/10, r1s Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 04 2010 21 Martha Custis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester General Dorchester Cambridge Hospital 8. Date of Birth (Month, Day, Year) Birthplace Country) (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months Hours Min. 1 M 2 R 76 08-07-1933 Va. 228-44-8680 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1. Yes 2 □ No Cambridge Dorchester Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21613 517 Robbins Street Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) County & Public Elementary/Secondary (0-12) College (1-4or 5+) School Cook 18. Mother's Name (First, Middle, Maiden Surnam∉11izabeth 17. Father's Name (First, Middle, Last) Be Flizabetha (unknown) Trader George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sophronia Rogers/Daughter 517 Robbins St., Cambridge, Maryland 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Dourial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bethel Cemetery 05-01-10 | Cambridge, Md. 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signatura Truneral Service Licensee 21613 524 Race Street, Cambridge, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician demol Devere /Medical Due to (or as a consequence of): Examiner direche of chexia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Rena The law requires that the death certificate be executed Hepalo anding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No for 4 ☐ Pregnant at time of death 5 Other (specify) ned by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an cate has page 2 s autopsy performed? 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner' Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

To the Hospital or Attending Physician: within 24 hours a

To the Funeral I

completely filled

RS 1

EEVAN EARABOLU MI)

and manner stated.

29c. License number D69234 29d. Date signed (Month, Day, Year) 2010

ad address of person who completed cause of death (Item 23a) (Type, Print) 30 Name BYRN STREET 503

29b. Signature and title of certifier

31. Date filed (Month

CAMBRIDGE MD

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	aryland /	-	artment of H tificate of D						
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Oci	incate or E	Catri	2. Date of Dea	ath 4	010	3. Time	of-Death
	Physicia Medic		William	Franklin	Day	y			Month	Pay	Year	11:15	AM
	Examin	er	4a. Facility Name (if not institution, g. Allegany Count		ome		4b. City, Town, or Cumb	Location of Death			ounty of Death Ilegany		
	Funeral		Social Security Number 6.		(In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Dec 2	h		place (State	or Foreign
	Director		223-18-5986 Usual Residence of Decedent	****	90	YIS.			Dec 2	<u>"1""191</u>	19[	VA	
	ıryland I-f show ied at	Director	10a. State 10b. County Alle	gany	10c. City, Tow		nberland					10d. Inside	City Limits es 2 □ No
	the Ma or 28a e notif		10e. Street and Number	J,			10f. Zip Code		1	10g. Citizer	n of What Cou		
	th with ms 23a	Funeral	28 Somerville A			T		21502			USA		
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at the Medical Examiner must be notified at	by	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Married</li><li>3 ☒ Widowed 4 ☐ Divorced</li></ul>	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No WW II		Vas Decedent of Hi FYes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		. Race - Americ Black, White, ecify:		
5-0	2 hour	Completed	15. Decedent's (Specify only highest	Education	16a	(Give k	lent's Usual Occupa	ation furing most of work	ing	16b. Kind	of Business In		
				College (1-4 or 5	+) C		O NOT use retired) truction_w	orker		con	structio	n	
				t)				18. Mother's Nam	e (First, Middle, (Price)		name)		
Maryland	nould b ind Mer s mark umatic	-	Albert Day  19a. Informant's Name/Relationship		198	o. Mailin	ig Address (Street a	and Number or Run	al Route Number	r, City or Tov	wn, State, Zip	Code)	
	and 2 sl Health a tem 27 li		Marna Morris	Frie				ourth Stree		mberla			1502
Baltimore,	t. Page tment c tant: If tjury or		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	ecify)	cemete	Gap	sition (Name of natory or other place Veterans C	emetery	5/7/2010		ntstone		MD
Bal	permit Depar Impor any in	3	21. Signature of Funeral Serve of Control	ensee		22	Name and Address. Scarpe 108 Vi	ellî Füneral H rginia Avenu	ome, PA e: Cumberl	and. ME	21502		
			23a. Part 1. Enter the disease or co shock, or heart failure. List only	emplications that caused one cause on each line	the death. Do	not ente	**				10	Approxim Interval B	etween
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	Examiner	_	Sequentially list conditions,	b. ————————————————————————————————————	, contact action		17.						
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	a consequence	of):							
	cate be executed physician and s the burial-transit		that initiated events resulting in death) Last	C. Due to (or as a	a consequence	of):							
68760	cate be physic the bu	edical		d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal deat		Ectopic pregnand Other (specify)	y		230	d. Date of deliv Month	ery Day	Year
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Records,	The law requate has beer	Completed				_		**	24a. Was autop perfo		24b. Were auto prior to co death? 1 \square Yes	mpletion of	
ital	ician: certifica rector, I	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			Othe	ace of Death (Chec				135.4	
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Division	tal or A		4 ☐ Homicide determine	building, etc		ziiii, 3ti e	set, factory, office	,	City or Tow		umber or nura	riodie ivan	iber,
	the Hospi nin 24 hou he Funera npleted fills	Medical	(Check 2 Medical Exa only one) 3 Certifying N	hysician: To the best of miner: On the basis of e urse Practioner: To the	kamination and/	or invest	igation, in my opinio	on, death occurred a	t the time, date a	ind place, an	nd due to the ca	iuse(s) and n	nanner stated.
	To t To t		29b. Signature and title of certifier				29c. License			29d. Date s	signed (Month,		
			30. Name and address of person wh	o completed cause of d	eath (Item 23a)	(Type, P		33280		11100		10	
			SUNIL GUPTA M 31. Date filed (Month, Day, Year)	1.D . 625 k	EVT Al	VEN	WE CLY	IBERLAN	DY WIF	215	02		
		State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 13 20 0 Cenus A. Saula											

7 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19:03 PM Vatting 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospita echardtown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August, 1, 1934 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F Country) Director 577-48-7340 Marvland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
Health and Mental Hygiene.
tem 27 is marked other than "natural", or items 23a or 28a-f sho viter traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Hollywood Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 24601 Hollywood Road 20636 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Bank 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lester Aloysius Mattingly, Sr. Madeline Bussler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail M Dean/ Daughter item 2 5705 Wingate Way, Cambridge, Maryland, 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Charles Memorial Gardens May 8, 2010 Leonardtown, Maryland Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hemo one unot Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner horacie Sequentially list conditions, Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Ve Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) 4 ☐ Pregnant a g ☐ Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of this certificate has page 2 death? 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? 2 🗌 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 KER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 \_\_ Natural 2 Accident injury 5 Pending work? 2 💢 No 1824 Investigation 4,2010 leter 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural R City or Town, State) Three North 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of ceftifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

06842

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Yrs Director May 14, 1946 New York 062-38-5938 63 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 🗌 Yes 2 🔀 No Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō items 23a 21045 United States 9243 Red Cart Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ò Specify If Yes, Give Year or Dates: 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced 'naturai", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) or realth and Mental Hy roorlant: If item 27 is marked orbor. y injury or other to be 17. Father's Name (First, Middle, Last) Be William Gresack Nettie Berger မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9243 Red Cart Court Columbia, Maryland 21045 Richard Dean/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department o important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 4/28/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Heman M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 canata ! Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscass or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of) burial Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month for Pregnant at time of death 5 Other (specify) 2 - No 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Tyes plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident s after death i Director; A the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, þ determined 4 Homicide City or Town, State) filled in within 24 hours a Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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101

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address

parke

600 North Wolfe St, Baltimore, MD, 21287

ted cause of death (Item 23a) (Type, Print)

egistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 25ay 2019<sup>ear</sup> DELAUDER EDWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 ፟ M 2 □ 1924 **Director** 86 218-16-0814 Apri Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 8425 Reichs Ford Road 21704 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married X Yes 1 Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Automotive</u> Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hilda Smith Edward I. Delauder Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reichs Ford Road, Frederick, Maryland 21704 Judy Bell / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery : 5/1/2010 Mt. Airy, Maryland Signature of Fineral Service License 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician/ disease or condition resulting in death) **Medical** Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-transi that initiated events quence of) resulting in death) Last to (or as a cons attending physician Physician/Medical Box 68760 IF FEMALE nse s yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No 9 Unknown P.O. ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy performed? has 2 🗷 No 1 Yes Was case referred to medical examiner? 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 💹 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: al or Attending P s after death. Il Director: After 5 $\square$ Pending Natural 1 Yes 2 No Investigation 6 Could not be Accident Suicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number

3. Time of Death

3.58 P

10d Inside City Limits

Approximate Interval Betweer Onsat and Death

Day

2 No

1 ☐ Yes 2 🛣 No

9. Birthplace (State or Foreign

Maryland

White

Registrar DHMH 17 Rev 7/2009

State

611

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Virginia Williams D'Orazio 2010 9:30 P May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year 1 🗆 M 2 🖾 F Months Hours Min. 84<sup>Yrs</sup> 213-22-2291 Director Maryland Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Director District ms 23a or 28a-f s must be notified 1 X Yes 2 No of Columbia N/A Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 1317 Rhode Island Avenue NW #405 20005 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural" 3X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry it. Page 1 and 2 should be filed within 72 in attrient of Health and Mental Hygiene. octant: If item 27 is marked other than "n cotant: If item 27 is marked other than "n cotant." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education School Teacher 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paddy Mary Williams Rose Joseph Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Rhode Island Avenue NW #405 , Washington, DC 20005 Michael Wayne D'Orazio Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) etopolitan Crematory¦May 7, Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 22. Name and Address of Facility re of Faneral Service Licenses 23a, Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annroximate shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) LMONH **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last and the burial attending physician Physician/Medical certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 0 Month Year 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. signed by t d be detach 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 🗌 No After this certificate Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) မ in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 24 hours after deat Funeral Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifier

Heme

State Registrar Leena Mahesh Kosandal, MD. 244
31. Date filed (Month, Day, Year) 32. Pegistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koseml

32. Degistrar's Signature

D0069166

24435 Mervell Dean Road, Hollywood, MD 20636

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 23, Day 2010 3:20 p. M Physician/ Filippelli Rosalyn D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Somerford Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Country)Oklahoma 1 □ M 2 🖾 F Months Days Hours June 12, Year 1919 90 Director 448-16-3216 Usual Residence of Decedent 10d. Inside City Limits 10a. State Maryland 10b. County 10c. City, Town or Location Frederick Director Frederick 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2100 Whittier Drive 21702 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ □XYes 2 □ No Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Adminstrative Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file alth and Mental H 27 is marked of traumatic even 2 Robert E. Darrah Elizabeth Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a if item 27 is 3610 42nd St., South, St. Petersburg, Florida Mary E. King - daughter Baltimore, other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery crematory or other place)
Stauffer Crematory Department of Important; If it any injury or conce. 1 Burial 2 Carcination 3 Removal from State 4-27-2010 Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility re of Funeral Service Livensee 21. Sign Stauffer Funeral Home ue 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ avdiomyopath disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Fctopic pregnancy in the past 12 months 1 Yes 2 V No ō Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ be 1 Yes 2 No 3 Probably 4 Unknown Records, Anemia Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an aastrolntesting Jas performe Hospital or Attending Physician; The this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 I 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 4-27-2010 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mont)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 6:40 m Harold Charles Fillyaw Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 18 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1933 South Carolina Min 1 🗷 M 2 🗆 F Months Hours 244**-**44**-**2768 77 Jan. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral United States 20011 Street NW # 287 <u>3700 North Capitol</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. 1 X Yes 2 If Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: Caucasian 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Government Locksmith Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emmie Hewett Marion Fillyaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32812 Orlando, FL 4108 Old Dominion Road Sherry Birckhead/ Step-Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date April 27, 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Lee's Crematory Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21, Signature of Funeral Service Lio 20019 Washington, DC 4001 Benning Rd. NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should to 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Hospital or Attending Physician: The law autopsy performed 1 Yes 2 No 2 18 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 22 7953 person who completed cause of death (Item 23a) (Type, Print) Call Adventist f bon 31. Date filed (Month, Day, Year) 32. Regis State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 23aPtI,26 pe me,g903,05/13/2010dhb
Red. No. Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 9:59 **Physician** Thelma T. Gaultney 15, 2010 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Hours 72 215-34-0254 2/27/1938 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene. "Internation of Items 23a or 28a-f show Important: If Item 27 is marked other than "ratural", or Items 23a or 28a-f show any injury or other traumatic event, It it is after Examination or the provided and any injury or other traumatic event, It is a featured and in the provided 1 ☐ Yes 2 Z X o Director MD Harford Street 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21154 1051 Priestford Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes XXNo SPWNite 3 Widowed 4 Wivorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maude Weaver Thompson Thomas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2448 Conowingo Rd., Bel Air, MD 21015 19a. Informant's Name/Relationship (Type. Print) Timothy D. Gaultney - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XX urial 2 ☐ Cremation 3 ☐ Removal from State 4/19/10 Bel Air, MD Bel Air Mem.Gdns 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Ane Al Service Licenses C. Kobert Harkins F.H.Inc.,600 Main St., Delta, PA complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COLECTOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner Peritonitis burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) Ö the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe certificate 1 ☐ Yes 2 Z No 2 **Z** No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0069118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 501 S. UNION AVE. HAVRE de GRACE, MD 21078 KHALID 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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		D	For State Certificate O	f Death	Reg 2. Date of Death	. No.	3. Time of Death			
ĺ	Physicia I Examir	n/	I. Decedent's Name (First, Middle,Last)  Matthew Scott Gray		Month April 28, 20		0900 hrs			
		4	a. Facility Name (if not institution, give street and number)  Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	1	4c. County of Death Washington	1			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Bii Forei	thplace (State or			
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	212 nould be id Ment is mark	٥t	19a Informant's Name/Relationship (Type, Print ) 19b. Mail	ing Address (Street and Number or N. Main St.,						
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	nore ages 1 ant of H at: If it		Burial 2 Cremation 3 Removal from State Smithsb	osition (Name of cemetery, other place) ourg Crematory	30/2010	Smithsb	urg, MD			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Licensee 22	Name and Address of Facility	oson Fu	neral Ho				
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i	/Medical		failure. List only one cause on each line.   Immediate Cause (Final disease a. Heroin intoxication				Death			
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			Pot Un State James of Apath (Horn 232)							
			30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examine	r 111 Penn Street, Baltim	nore, MD 2120	)1				
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Registrar

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<u>S</u>	italor Insaft ral Dir led in	al C		Ballaling, etc. (epochy)				City 07 7011			
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical Certificate:	(Check 2 Medical Exam	sician: To the best of my knowled iner: On the basis of examination a	nd/or invest	igation, in my opinio	n, death occurred a	t the time, date a	and place, and c	due to the cau	use(s) and manner stated
	o the	ž	only one) 3 ☐ Certifying Nur- 29b. Signature and title of certifier	se Practioner: To the best of my kn	LECTE	29c. License	number	ce, and due to the	e cause(s) and r 29d. Date sign	nanner as sta led (Month, I	Day, Year)
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	,		30. Name and address of person who	completed cause of death (Item 23	Ba) (Type, F	Print) 1:40	SPICE OF	- FRED	Felow	1001	577 21701
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	Stat	e	29b. Signature and title of certifier  30. Name and address of person who of the control of the	32. Registrar's Signature	1. 19	arkel	/		,		,
	Registra	1	****								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 04 22 2010 9:19 A M KATHRYN GILES MARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT EASTON WILLIAM HILL GARDENS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 XF 03/29/1915 95 NJ 142-09-4157 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State orant: If tem 27 is marked other than "natural", or items 23a or 28a-f show njury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo BRIDGETON NJ CUMBERLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 6 MALAGA DRIVE 08302 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 Man No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental JULIUS GOSSIAUX EDNA EARNEST ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau JAMES P. GILES/SON 3750 LAKE SHORE DR., CHICAGO, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MARY'S CEMETERY 04/29/2010 BRIDGETON, NJ 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON ST., EASTON, MD 21601 JOHN R MERCERO Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Adult Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **N**O 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 62 Other (Specify) Ass. Liviv 2 No 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: d in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide nin 24 hours af the Funeral D npletely filled ii 29a. Certifier 1 Tocrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the

6 RS

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State Registrar

31. Date filed (Month,

The mas

29b. Signature and title of certifier

Krystal

CRNP 32. Registrar's Signature

1 CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 Outchman's Lane

29c. License number R077623 29d. Date signed (Month, Day, Year)

04-22-2010

Easton, maryland 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hobell Kocav Stella Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 □ F (Month, Day, Year) Nov 11. 1912 Director 212-18-1724 97 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 213 Emily Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify: "natural", white Completed 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Allegany Co. Infirmary dietary aide marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Kocay Josephine (Gluszka) Kocay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Klosterman Avenue LaVale MD 21502 S 11 Klosterman Avenue permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Harry Hobell son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Sunset Memorial Park 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/8/2010 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Error Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an Were autopsy findings available prior to completion of cause of cate has I autopsy After this certificate Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Pesidence} \) Residence \( 6 \) Other \( \text{Specify} \) 1 ☐ Yes 2 ☐ No မှ 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A bleted filled in by the fu Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M Regierrar's Signature State

5 DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 4:15 P.M Holden 25 ,2010 April Fulton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Somerset Home TAWES Nursing If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**∑** M 2□ F 213-18-4858 Maryland May 6, 1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1**Y** Yes 2 □ No Princess Somerset Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21853 U.S.A. 30380 Maple St , Ap+ 205 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) School Bus Contractor DRIVER BUS Ith grade permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Adams Bertrand Jendie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 Princess Anne, Ml, 21853 30380 Maple Apt. Holden - wife Bessie Li 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ♀ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5-1-10 Marion Station mel Ebenezer U.M.C. Cemetery 22. Name and Address of Facility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee Cove 5+, Crisfield md, 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cantra **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to fur as a consequence of Physician/Medical Examiner led by the attending physician and detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? Year Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 29c. License number 87 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 0620 AM ALIC 04 2010 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Belin Moreste HOS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11/30/1920 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Days 1 ☐ M 2 💢 F 578-22-0662 Washington D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Berlin MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ō 21811 USA "natural", or items 23a 1 Meadow St. Unit 112 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 08:11|30|20 DOD:4|28|10 Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Hardell William Crane ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trauonce. Susan Holland / daughter 1303 Molesworth Rd., Parkton, MD 21120 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ KBurial 2 □ Cremation 3 □ Removal from State St. Stephen's Chrchyrd 5/3/2010 Kingsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 wear Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final last **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? yes 2 No 2 🗆 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 4 hours after death. 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of Injury 27. Magner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation I Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled LIZ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9733 BA 10 ank olon Muzam 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 HICKMAN MAE VIVIAN 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN BEKLLIN

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, AUG. 29, AUG. 29, Birthplace (State or Foreign Country)
 DELAWARE 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex 1 □ M 2 🗓 F Months 89 219-36-5901 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🛛 No BISHOPVILLE MARYLAND WORCESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21813 12321 DIXIE DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. WHITE 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **MCCABE JERUSHA** ROBERT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RITA H. TAYLOR/DAUGHTER 12242 DIXIE DRIVE, BISHOPVILLE, MD 21813 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GRANITE MEMORIAL 4 Donation 5 Dother (Specify) FNTOMEMENT 4/30/10 BISHOPVILLE, MARYLAND MAUSOLEUM
22. Name and Address of Facility 21. Signature of Funeral Selvice Lipensee HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of) Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ungestive Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 D Unknown 9 Unknown

Physician /Medical Examiner Examine

permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other ODGE.

**Physician** 

/Medical

**Examiner** 

Directo

by Funeral

Completed

Be

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**Funeral** 

Director

s 23a or

with the Maryland

80:001

DOD: 4/25/2010

0261/60/30:500

55#219-34-590.

HICK MAN, VIVIAN

Baltimore, Maryland 21215-0036

Physician/Medical

2

Medical Certification: To Be Completed

29b. Signature and title of certifier

APR 29

physician and s the burial-trans Division of Vital Records, P.O. Box 68760,

20 M

Anema	contributing to death but not resu	1 □ Yes 2/2	No 3 Probably 4 Unknown			
Hypertensia	on		<u>.</u>	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
25. Was case referred to medical			26. Place of De	eath (Check only one)		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	Other: 4 Nursing	Home 5 ☐ Residence 6	Other (Specify)	
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	28b. Time of lnjury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred	
3 Suicide 6 Could not l	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier 1 Certifying P	Physician: To the best of my known immer: On the basis of examinat	wledge, death occurred tion and/or investigation	at the time, date and pla	ce, and due to the cause(s)	and manner as stated. place, and due to the cause(s)	

Attending

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9733 Healthway Drive Berlin, MD 21811 31. Date filed (Month, Day,

State Registrar

Item#8 ok Diana, WCHD, SLU, 5.6.10 Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician:

certificate has been

this

To the Funeral Director: completely

	Sequentially list conditions, b						
<b>6</b>		ue to (or as a consequence of):					
	cause. Enter Underlying Cause						
a	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):					1
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Ě	IF FEIVIALE:	23c. If yes, outcome of pregnancy	y	_		23d. Date of deliver	у
=	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy	1	Month	Day Year
5		4 Pregnant at time of death	5 Other (Specify)		1		
3	1 Yes 2 No 9 Unknown	9 Unknown	_				
Ξ	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
[≊	Diabetes mellitu	IS			1 Yes 2	✓ No 3 Pro	bably 4 Unknown
ᇙᅵ	Blabetes mellico						
1					24a. Was an autopsy		utopsy findings available completion of cause of
밁					performed		completion of cause of
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ا ت	25. Was case referred to medical		26.Plac	e of Death (Check only	one)		
9	examiner?  1 ✓ Yes 2 No	spital: 1 Inpatient 2 ER/0	Outpatient 3 DOA	Other Nursing Ho	ome 5 Resi	idence 6 🗸 Othe	r: Scene
3	27. Manner of Death		. Time of Injury 28c, Inju	ry at Work? 28d	. Describe how	injury occurred	
5 ∣	1 Natural	(Month, Day, Year)	1	Yes 2 No			
₹	2 Accident - Investigation						
Ĭ	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, office	ouilding, etc. 28f.	Location (Stree or Town, State)		ural Route Number, City
= 1		(0			or rown, state,	,	
Σį	4 Homicide determined	(Specify)					
2	4 Homicide  29a. Certifier 4 Continue Physician	1	eath occurred at the time of	ate and place and due	to the cause(s)	and manner as stat	ed
	4 Homicide  29a. Certifier 1 Certifying Physician	n: To the best of my knowledge, de					
edical cel	29a. Certifier 1 Certifying Physiciar (Check only 2 Medical Examiner: C	1		n, death occurred at the	time, date and		ne cause(s)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Margarita Korell MD

May 5, 2010

1433 hrs

10d. Inside City Limits 1 Yes 2 No

Approximate Interval 8etween Onset and

Death

KINNOMON, Robert

Box 68760	
P.O. Boy	
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of Vital	
Division of Vita	
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	Physicia	n/	Decedent's Name (First, Middle, Last)  The state of					2. Date of Dea	Day Ye	3. Time of Death	
	Medic	al	Robert Dewitt Kin  4a. Facility Name (if not institution, give street and no	namon		4b City Tow	n, or Location of Dea	March	28 201 4c. County of E	D 1212 PM	
	Examin	er	Memorial Hospital			East		ш	Talbe		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 You Months Da			h 9. y, Yearl O 2 Q M	Birthplace (State or Foreign ary Tand	
	Director		219-34-2808 1 MIM 2 LIF Usual Residence of Decedent	/ 2	1/5.			pail. 12	, 1930   1	laryrand	
	yland •f shov ed at	ctor	10a. State 10b. County	10c. Cit	y, Town or Loc		Cambridge			10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	ne Mar or 28a notifi	Dire	MD Dorchester  10e. Street and Number			10f. Zip Coo			10g. Citizen of Wha		
	with the s 23a oust be	Funeral Director	312 Maryland Avenue				21613		USA	. 33, .	
	r item iner m	/ Fur	Armed F		S. 13. V	Vas Decedent Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.	
036	rs after ral", o Exam	ted by	3 ☐ Widowed 4 ☐ Divorced 1 KL Yes	s 2  No live 1961-6 Dates:	54 1	☐ Yes 2 🛚	No Specify:		Specify:	white	
2-0	"2 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade complete	d)	(Give k	ent's Usual Oci ind of work do	ne during most of wo	rking	16b. Kind of Busin	ess Industry	
212	vithin 7 jiene. or than the M		Elementary/Seconday (0-12) College	(1-4 or 5+)		NOT use reti Sports	announcer		rad	io	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		•		1 _	me (First, Middle,	,		
<u> </u>	ould be d Men marke matic	8	Brice G. Kinnamon  Carolyn Layton  19b. Mailing Address (Street and Number or Rural Route Number, City  212 Mayurland Ann Combail doe M					7. 0.40			
Σ	d 2 sho alth an 27 is rr trau		Geraldine Kinnamon	wife							
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State 20b. F	Place of Dispos emetery, crem	sition (Name or natory or other	olace)	Date	20c. Location - City		
E E	Pag and Tele		4 Donation 5 Other (Specify)	East	t New M				East New neral Hom	Market, MD	
Ba	permit. Departr Imports any inju	Į	21. Signature of Funeral Service Licensee				ist St., (				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate								Approximate Interval Between		
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POX	sician: The law requires that the death certificate be certificate has been signed by the attending physici rector, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months?	e Birth 2 🗌 Feta egnant at time of a	al death 3 🗌	Ectopic pregi Other (specify			23d. Date of Month	f delivery Day Year	
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<u> </u>	sician: certific irector,	m	25. Was case referred to medical examiner?  1  Yes 2  No Hospital:	7	<i>f</i>		. Place of Death (Che				
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Division of Vital Records,	al or Ar s after I Direc d in by			e of Injury - At ho ding, etc. (Specify		et, factory, on	De .		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
<b>-</b> .	to the hospital or Attending Physician: within 24 hours affect death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the b								
-	o the l	Me									
	~ > <b>r</b> * ∪		Mal //n=			D	005696	69	March	30, 2010	
			30. Name and address of person who completed car	use of death (Item	23a) (Type, Pi	rint)	4		- 1 4	, , ,	
	Stat	e	only one) 3 Certifying Nurse Practioner  29b. Signature and title of certifier  30. Name and address of person who completed cate of the service of the serv	Registrar's Signa	219.	South	NAShing to	Street,	Egston, 1	naryland 21601	
	Registra		MAY 13 2010 \alpha	136×6 /	d goa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 2010 Year 27, 10:50 AM Richmond Keeney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** <sup>Year</sup>1930 1 XM 2 🗆 F Days Hours June 27 Director 79 Massachusetts 027-22-3382 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 20420 Remsbury Place 20886 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black. White, etc. 1 Yes 2 No ō þ 1 Never Married 2 x Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Completed 3 Divorced 4 Divorced Year or Dates.1952-56 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Membership Director Air Force Association 1 and 2 should be filed with Health and Mental Hygic item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Morgan Keeney Vesta Richmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail C. Keeney/wife 20420 Remsbury Place Montgomery Village, MD 20886 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t other 1 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Final Journey Crematory 4/30/2010 Woodbine, Maryland 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 Marita none 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani Serticemia Medical resulting in death) Due to (or as a consequence of) Examiner 8 months Metastatic Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Day Year Pregnant at time of death 5 Other (specify) Month 1 Yes 2 L 9 Unknown signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Lymphocytic Leukemia 1 Yes 2X No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 performe 1 Yes 2 No After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 🗌 Yes ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation hours a er death the 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ģ determined City or Town, State) within 24 hours a

To the Funeral D Hospital Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only o

1241

State Registrar 29b Signatu

31. Date filed (Monti

and title of certifie

Melnick 911

eddress of person who completed cause of death (Item 23a) (Type, Print)

Russell Avenue

gistrar's Signature

recen

29c. License number

D19294

Gaithersburg, Maryland 20879

29d. Date signed (Month. Day, Year)

April 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) mc Queen Elizabeth 1:09 Maria mall 2010 Cambriage County of Death Doychester 4a. Facility Name (If not institution, give street and number) 6 lasgow street 1510 If Under 1 Year Date of Birth (Month, Day, Ye Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 250-92-3 1 □ M 2 □ F Days Hours SOUTH CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1XYes 2 □ No DORCHESTER **MARYLAND** CAMBRIDGE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1510 GLASGOW ST. 21613 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify 3X Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LINE ASSEMBLER **TOBACCO** 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PEARLY REED NORA LEONARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEARLY MACK MCQUEEN, III / SON 1510 GLASGOW ST., CAMBRIDGE, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3X Removal from State 5/17/2010 4 Donation 5 Dother (Specify) ST. JAMES METHODIST CHURCH CEMETERY MARION, SC 21. Signature of Fun 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Adulf Thrive disease or condition resulting in death) culientally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year

**Examiner** Examine certificate be executed burial-tran attending physician for use as the buria

signed by t

certificate

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al or Attending F safter death. I Director; After d in by the funera After

within 24 hours a To the Funeral D Hospital

P.O. Box 68760,

Division of Vital Records,

Physician

Examiner

**Funeral** 

Director

28a-f show

death with

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i 2 should be filed with and Mental Hygier 7 is marked other the

permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any injury or other traun once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, It ∈ Modical Expanier must be retified at

/Medical

Physician/Medical þ Completed Be Certification: To

	sons contributing to death but not resulting in SCULAR DEMO	
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Part II. Other significat		contributing to death but not res	sulting in the underlying	ng cause given in Pari		bacco use contribute to the cause of death? es 2 ☐ No 3 ☐ Probably 4 ☐ Onknown	
					24a. Was a autops perfori	sy prior to completion of cause of	
25. Was case referred	to medical			26. Pla	ce of Death (Check only on	ne)	
examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 □	DOA Other: 4 🗆 I	Nursing Home 5 Reside	ence 6 Other (Specify)	
27. Manner of Death Natural 5 2 Accident	Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 [		ow injury occurred	
3 ☐ Suicide 6	Could not be determined	28e. Place of Injury - At h	ome, farm, street, fac	28f. Location (Si	(Street and Number or Rural Route Number,		

4   Horricide	building, etc. (Specify)
29a. Certifier (Check only one)	cian: To the best of my knowle er: On the basis of examination and manner stated.

edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated n and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

unacole Sheehan D.O.

e of death (Item 23a) (Type, Print)

CHC 503A Mair St Cambridge MD 21613 32. Reg strar's Signature

Part &

State Registrar

Medical

DHMH 17 Rev 1/2001

5 DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year CHRISTINE F. McGARRY 10:53 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Coasta the Social Security Number If Under 1 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 09/19/1946 1 □ M 2**X**□ F Months Days Hours Min Pennsylvania 197-36-1239 63 Yrs Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Somerset Crisfield 1 Yes 2 XNo 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a o Funeral with 26498 Old State Road 21817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ith and Mental Hygien 27 is marked other the r traumatic event, the Healthcare Phlebotomist Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph J. Kurtz Jean E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai Henry J. McGarry (Husband) 26498 Old State Road - Crisfield, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place Hillside Cemetery 4 Donation 5 Other (Specify) 4/29/2010 Roslyn, PA Signatural Spirit Lancee

Robert H. Bradshaw. 22. Name and Address of Facility Sons Bradshaw & Funeral Home Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALIGNANT LIVER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 ELAB 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOSACR 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Signature and fitle of certifier 1)0018410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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egistrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2010 **Physician** 12:20 PM APRIL MOORE JOYCE Η. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Days **Funeral** Months 1 □ M 2 🖾 F 19, 1933 VIRGINIA JAN. 579-42-4739 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, "n. Modes Examina must be multified at 1 ☐ Yes 2 No Director DELAWARE SUSSEX SELBYVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 19975 35953 JOHNSON LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: WHITE 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "ny Elementary/Secondary (0-12) College (1-4or 5+) BUS ATTENDANT COUNTY SCHOOL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOROTHY GROCE **JAMES** L. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 35953 JOHNSON LANE, SELBYVILLE, DE. 19975 THOMAS GORDON MOORE/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State DELMAR, DELAWARE CREMATORY OF DELMARVA 4/26/10 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility 21. Signature of Juneral Service Licensee HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death Woulks 23a. Part 1. E iter the disease, or complications that caused the dishock, or heart failure. List only one cause on each list. Do not enter the mode of dying, such as cardiac or respiratory arrest Metastatic Immediate Cause (Final bookingcal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2N No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24

To the F

complete 29d. Date signed (Month, Day, Year) 29c. License number

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Baltimore, Maryland 21215-0036

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Box 68760,

P.O.

Records.

Division of Vital

State Registrar 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nillidge Brodulia 1209 Coastel Highway

31. Date filed (Month, Day, Year)

APR 29 2010

April 1209

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Ferwart Island, De

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State

Registrar

ORIGINAL

BROADWAY STREET FROSTBURG, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Regis var's Signature

IM MI

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	⁄lental Hyg	iene	1 ~ 0 0 0	
				rtificate of Death	R	eg. No2010	15066	
	Physicia	n/	1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Edward Anthony Pop	ielarski	2. Date of Death	h 7 <b>,</b> Day 2010 Year	3. Time of Death 08:12 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	riay /	4c. County of Death	00:12 A ···	
	LXamiii		Union Hospital	Elkton Cecil				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	9. Birthp	lace (State or Foreign	
	Director		222-10-1390   1 M M 2 L F   86 Yrs.	,	Nov. 23.	, 1923   D	elaware	
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the the	a or a	al D	10e. Street and Number	10f. Zip Code	1	l0g. Citizen of What Coun		
tiv Ki	Donard was a fear and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	245 Maloney Road	21921	76 N M .	United Sta		
o dea	or ite	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  13. Married Forces?  1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	etc.	
15 af	ıral", I Exar	edk	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates 1943-45	1 ☐ Yes 2 🚺 No Specify:		Specify: Whi	te	
ا <b>ئ</b>	"natı edica	plet	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing	16b. Kind of Business Inc	dustry	
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/lar	Menta arked atfc ev	입	Anthony Popielarski	Joseph	nine Man	rkowski		
Mar	raum			ing Address (Street and Number or Rura		•	(ode)	
<b>e, ⊳</b>	Health em 27 ther t		Joyce V. Hatfield/Daughter 102  20a. Method of Disposition 20b. Place of Disp	Prangs Lane, New			Otata	
nor	ont of ht: If it		1  ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		20c. Location - City or To	1	
Baltimore, Maryland 21215-0036	oortar v injur			Conception Cem. May  2. Name and Address of Facility H-		e for Funera		
n e	E 9 T 6 9	() ()		103 W. Stockton St				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between								
Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)								
	xaminer		Due to (or as a consequence of):					
		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
Sorted.	nd transit	xami	Cause (Disease or linjury that initiated events c.					
te be executed	cian a	dical Examiner	resulting in death) Last Due to (or as a consequence of):					
<b>/60</b>	physics the t	edic	d					
	ending use a	M/ue	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	Estapia programav		23d. Date of delive	ery	
<b>BOX 68/</b> death certifica	he atte ed for	Physician/Me		Other (specify)		Month	Day Year	
that the	d by t		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?	
S, F	signe Id be	d by	COLON CONCINOMA		1 □ Y€	es 2 🗆 No 3 🗆 Prot	oably 4 Unknown	
Ord W requ	s beer	Completed	Dieseles rellitus insuun s	FERDANT	24a. Was ar		osy findings available	
DIVISION Of VITAI RECOLDS, tal or Attending Physician: The law requires	ate ha	Som	Chronic Systemetre Armay		autops perform 1 \(\sum \) Yes	med? death?  2 X No 1 Yes	mpletion of cause of	
tal	ertifica ector, I	Be (	25. Was case referred to medical examiner?	26. Place of Death (Chec				
T VI	this c	٠ <u>۲</u>	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of injury 28b. Time of			ence 6 Other (Specify	)	
	th. After fune	cate	1 Natural 5 Pending (Month, Day, Year) injury	of 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe no	w injury occurred		
1SIC	er deg ector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		reet and Number or Rural	Route Number,	
	urs aft ral Dii				City or Town			
Hosp	24 ho Fune eted fi	Medical	29a. Certifier  (Check  (Check	stigation, in my opinion, death occurred a	t the time, date an	d place, and due to the car	use(s) and manner stated.	
To the	within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,		
	\		P. V. Nonge D.	00065733		5/10/10		
4	) <sub>X</sub> /			Print) E. HIGH STREET	ELKT	UN ,MB 2191	_1	
	Stat Registra							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:06 PM Suzanne Wilson Palmer 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death is bu Nicomica 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 T F Min. 7 /2311938 71 Yrs Washington DC 577-54-4905 Director Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified MD Worcester Berlin 28a-f 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 21811 Crows Nest Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. 2 X No filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 College (1-4 or 5+) Elementary/Seconday (0-12) Il Hygiene. Realtor ong & Foster Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Wilson Margaret Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Palmer 24 Crows Nest Lane Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Henlopen Crem. 4/29/2010 Frankford 21. Signature of Juneral Service License 22. Name and Address of Facility The Burbage Funeral Home 108 W<u>illiam</u> St. Berlin, MD 21811 23a. Pay. Enter the disease or complications that caused sock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 pronths?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death Day q Unknown 9 Unknown after death.

Director: After this certificate has been signed by the his his the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 Yes 25. Was case referred to medical examiner?

1 Yes No Be 26. Place of Death (Check only one) Hospital Other: ၉ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Doth Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injuly occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Registrar
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State

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth JOHN EDWARD RIGGIN 12:09 AM 010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice the Lak alisbur WICOMICO 94 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 XM 2 □ F 77 Months Hours Min. 0497671932 **Director** 215-26-5487 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Somerset Crisfield 10e, Street and Number 10g. Citizen of What Country? Funeral 4720 Poplar Street 21817 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 → No Kore If Yes, Give Year or Dates. War Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 □ No Korean 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Paintbrush College (1-4 or 5+) Supervisor Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard Riggin Sadi<u>e Mason</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Geneva Riggin (Wife) 4720 Poplar Street - Crisfield, Maryland 21817 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other pla-Park 4/30/2010 Crisfield, Maryland Memorial 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Main Street - Crisfield, Maryland 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MRTASTATIC ANCRRATIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Yes 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by e II No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA HOSPICE 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Jeath Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00058410 4/27/00

Registrar

DHMH 17 Rev 7/2009

State

21807

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAN

31. Date filed (Month

80

BOX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of	Marylar		artment of			lental Hy	giene	;		
			Registrar  1. Decedent's Name	(First Middle 1 s	eet)		Cer	tificate of	Death			Reg. No	201	0	15069
	Physicia		7. Decedent 5 Ivanie	(i iist, iviidale, La	LINDA	T.OI	JISE	SHUCK			2. Date of De Month	ath Da 3	y Yea 2010	ır	3. Time of Death
	Medic Examin		4a. Facility Name (if r	not institution, giv			7101	4b. City, Town, o	or Location	of Death	May		. County of D		12:16 A M
			_Frederic	k Memori	al Hospi	ital		Frede	rick				Freder		k
ı	Funeral Director		5. Social Security Nui 311-50-96	mber 6.8		'. Age (In yrs. I	ast birthday) 62 Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birl (Month, Da Feb. 28	th y, Year 10	9.	Birthpl	ace (State or Foreign ry) 11gan
		To Be Completed by Funeral Director	Usual Residence of Decedent								1100. 20, 1540			riiciiigair	
	yland •f sho ed at						ty, Town or Location								0d. Inside City Limits
	r 28a notifi		VA Shenandoah Str				rasburg					1 ☐ Yes 2 ☐ XNo			1 Yes 2 XNo
	vith th			23 Old Grade Road			22657					_	S.A.	Count	ry?
	eath v tems er mu		11. Marital Status	ade Noa	12. Was Deced		3. 13. V	Vas Decedent of F	lispanic O	rigin? (Spe	cify Yes or No-		14. Race - Ar	nerica	ın Indian.
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give			2 X No	If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 [X] No Specify:				Rican, etc.)		Black, Wi Specify: W		
9	hours natura lical E		15. Decedent's Education			16a. Decedent's Usual Occupation					16b. Kind of Business Industry				
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2	d with lygien ther ti		12				hor	nemaker					wn hom	e	
Baltimore, Maryland 21215-0036	be file ental H ked oi ic ever		17. Father's Name (First, Middle, Last)  Irving John Foster				18. Mother's Name (First, Mi Donna Monroe					ldle, Maiden Surname)			
ary	hould and M s mar umat		19a. Informant's Nan				19b. Mailin	19b. Mailing Address (Street and Number or Rural Route Num				hber, City or Town, State, Zip Code)			
Σ	nd 2 s ealth a m 27 i		Larry Ced		k			ld Grade				VA	22657		·
ore	Page 1 aument of H ant: If iter ury or oth		20a. Method of Dispo 1 ☐ Burial 2 ☐		Removal from S	tate 20b. F	lace of Disposemetery, crem	sition (Name of natory or other plac	ce)		Date	20c. Lc	ocation - City	or Tow	n, State
<u>=</u>	permit. Page 1:8 Department of H Important: If ite any injury or of		4 Donation 5	5 🗆 Other (Speci	fy)	L Eu		natory or other place Shirley Home & Cr			6/2010	Ber	ryvill	le,	Virginia
Ba	permit. Departr Imports any injt		21. Signature of Fund	IND A	1 Hen		22	Name and Addre	E UN	eral,	Home	, ,	Racons	: 1//	IR MO
		ner	23a. Part 1. Epter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
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	Medical Examiner		resulting in death)	ſ	Due to (or	as a consequ	ienc of):	,							
			Sequentially list cond if any, leading to imm	uence of):							+				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  C.  Due to (or as a consequent)						_						
	cate be executed physician and the burial-transit	alE													
9	cate b physi	edical			d					_				$\pm$	
200	certifi anding use as	ΣΙ	F FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan				tal death 3 Ectopic pregnancy					23d. Date of delivery  Month Day Year			
ROX	death ne atte ed for		1 Yes 2 No 4 Pregnant at time of de												
5.	at the d by tl letach		9 Unknown Part II, Other signific	ant conditions of			ulting in the ur	nderlying cause giv	/en in Parl	H.	220 Did to	bacco III	so contributo	to the	ogues of death?
S,	sician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as	To B	Part II. Other significant conditions contributing to death but not resulting in the underlying cause  End Stay & Renal disease					, , ,	200. 2.4			tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown			
Vital Records,	w requ			•							24a. Was a		24b. Were a	autops	sy findings available
rec	The lay										autop perfor 1  Yes	rmed?	death'	?	pletion of cause of
<u>a</u>	cian: ertifica ector, p		25. Was case referred examiner?		Hospital:			26. Pl	ace of Dea	ath (Check		2 23 140		50 2	
DIVISION OF VII	Physi this c		1 Yes 2 2 27, Manner of Death	No		Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death  1				Injury work?  M 1 ☐ Yes 2 ☐ No  ome, farm, street, factory, office 28f.			- 1	28d. Describe how injury occurred				
N SI	or Atte	erti	3 Suicide 6 Could not be			8f. Location (Street and Number or Rural Route Number, City or Town, State)									
วิ	spital	Medical C	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.												
	to the rospital or Attending Prysician: The is within 24 hours after death.  To the Funeral Director, After this certificate his completed filled in by the funeral director, page		only one) 3 Certifying Nurse Practioner: To the best of my				and/or investigation, in my opinion, death occurred at the knowledge, death occurred at the time, date and place, a			ne time, date and place, and due to the cause(s) and manner			e(s) and manner stated		
	Vitl Con		29b. Signature and title of certifier			29c. License number				29d. Date signed (Month, Day, Year)					
		ŀ	30. Name and address	s of person who	completed cause of	of death (Item	23a) (Type. Pr		041	7		5/	3/20	110	
		_	Hemen:	Shah	650		conces	1	an !	W.	Freo	Per	18K	٨	21702
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Darrell Leotis Slaubaugh 2010 12:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakland Nursing & Rehab Center 0akland Garrett 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Months Hours Min. 097231 Country) 87 Director <u>35-</u>22-5466 WV Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV 1 🗌 Yes 2 😿 No Preston Bruceton Mills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 135 Filly Lane 26525 USA "natural", or items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc <u>ک</u> 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 8 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ pe Charles Elmer Slaubaugh Mae Leatha Whitehair 1 and 2 should b if Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Helmick/Daughter 135 Filly Lane Bruceton Mills, WV26525 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce. other 20b. Place of Disposition (Name of cemeral) Cremytory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Church Cemetery 4/10/2010 Eglon, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hinkle Funeral Home Inc. Scot POBox 186 Davis, 26260 WV23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Ope et and Dath disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a conseque re of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 2 ANO Yes 1 🗌 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 400 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne: 1 Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? ☐ Accident Investigation 2 🗌 No within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pactioner: To the best of my knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oakland MD 21550 255 N FO St. Suite1 Savopoulos 31. Date filed (Month, Day, Year) State 32. Re istrar's Signature

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May **Physician** 2010 LEONARD CRAIG SMITH 6:50 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1930 Monument Road Myersville Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 11, 1943 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 X M 2 □ F 215-44-9851 Yrs. 66 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1930 Monument Road 21773 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 → No If Yes, Give Year or Dates: 62-68 or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Specify: White 62 - 68"natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magonce. Elementary/Secondary (0-12) 12 College (1-4or 5+) Metalurgy Technician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Moats Smith Marjorie Edna House ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta L. Smith/wife 1930 Monument Road, Myersville, MD 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory May 11,2010 Hagerstown, Maryland 4 □ Donation → Other (Specify) 21. Signature / Funer 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CA 20/12 /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above and a signed by the attendant above a signed by the attendant and a signed by the attendant a burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month signed by the and be detached to 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐Yes 2 ∏ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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		Registrar Co	ertificate of Death	1	g No2 U U 10 U / Z						
Physicia	an/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month		3. Time of Death					
Medi		Roger Powell Staiger  4a. Facility Name (if not institution, give street and number)		April	29, 2010	[3:00 p. <sup>M</sup>					
Examir	ner	49643 Potomac River Drive	4b. City, Town, or Location of Death Scotland		4c. County of Death						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	St. Ma:	ry S hplace (State or Foreign					
Director		147-03-2640 1 M 2 □ F 88 Yrs.	Months Days Hours Min.	Month, Day, Y	(ear) Coo	intry) W_Jersey					
M		Usual Residence of Decedent		111/23/1	721   Ne	w Jersey					
yland f sho ed at	Funeral Director	10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits					
Mar 28a- potifij	<u>i</u> .	Maryland St. Mary's Scot1	and			1 🗌 Yes 2 🖾 No					
th the	ョ	10e. Street and Number	10f, Zip Code	10	g. Citizen of What Co	untry?					
ms 2	ner	49643 Potomac River Drive	20687		USA						
r dea	굣	11. Marital Status	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White						
036 s afte "al", c	d by	1 ☐ Never Married 2 ☐ Married 1 🛣 Yes 2 ☐ No If Yes, Give   Year or Dates,	1 ☐ Yes 2 🛣 No Specify:		Specify:	White					
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Ya Jid be Men Marken Marken	-	Charles Jules Staiger		Powell							
ore, Maryland 21215-0036  1e 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			ling Address (Street and Number or Rura			Code)					
and 2 Healt Healt em 2		Roger P. Staiger, Jr./Son P.0  20a. Method of Disposition 20b. Place of Disp	Box 136, Scotlar								
Page 1 Page 1 ant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ematory or other place)		0c. Location - City or						
Baltimore, permit. Page 1 and Department of Hea Important. If item: any injury or other			eld-Echols 05/0		Charlotte						
Dep		Edward N. Brinsfield, Jr. M00052									
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate					
Physician/	67 9	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	on ith EMETAS-	TAGIC.		Interval Between Onset and Death					
Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	71. 41. 41. 67.13	1434							
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7 =	Examiner	if any, leading to immediate Due to (or as a consequence of):									
and trans	xan	Cause (Disease or iinjury that initiated events c.									
r <b>60</b> ate be executed ohysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):									
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<b>BOX 68 /</b> death certifice he attending p ed for use as t	icia	in the past 12 months?  1  Live Birth 2  Fetal death 3 1  Pregnant at time of death 5	Cther (specify)		Month	23d. Date of delivery  Month Day Year					
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that the	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?					
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The la	, E			autopsy performe	death?	2 No					
ctor,		25. Was case referred to medical examiner?	26. Place of Death (Check		3110						
hysic his c	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5X Residenc	ce 6 Other (Specia	(y)					
Ing F	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  28a. Date of injury (Month, Day, Year) injury	work?	28d. Describe how	injury occurred						
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al or Attending Physician: The law requires s after death. Indirector: After this certificate has been signed in by the funeral director, page 2 should be	Ce	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,					
Spita bours ineral d filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									
DIVISION OF VITAL RECORDS, P.O. BOX 687  To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ple completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.		only one)  2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at	the time, date and r	lace and due to the co	ause(s) and manner stated					
Vith Con		29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)					
		) // MD	D 56096		4-30-10	>					
na		30. Name and address of person who completed cause of death (Item 23a) (Type,	D 56096  Print) 8MAH ASSOC	INTEC	U 57 1 VIII-	MAN 25710					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death april Month Physician/ 405 Marvin Slyvester Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT MEMORIAL Hospital AT EASTON ASTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 2 M 2 □ F Months Hours 0<sup>M</sup>40<sup>nth</sup>2<sup>Dev, Year</sup>934 MaryTand 76 Director 217-30-9878 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County hours after death with the Maryland Director 1 Yes 2 No RockHall Md. Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt.106 Funeral 21661 5795 Chesapeake Villa Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married 2 X No ☐ Yes Completed by 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Specify: Black 3 - Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) ACME Line Worker 8 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland ပ္ Hopkins Virginia Sisco Moses t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sir Barton Court, Newark, De. 19702 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr <u>Phyllis Henry/Daughter</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 05-01-10 | Rock Hall, Maryland Aaron Chapel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home Co) Road 298, Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 50 disease or condition resulting in death) Medical Due to (or as a sequence of): Examiner NVON Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ending physician use as the burial Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown the a g Unknown P.O. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Hopatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury 5 Pending 1 🖂 Natural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check within 2 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOG 53110 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis DeShields, M.D., 219 S. Washinton St., Easton, Md. 21601 3RS 31. Date filed (Month, Day, Year) 19 2010 32. Fegistrar's Signature

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State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #171 - State FH, TCHD, 4/27/10, rls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02:59 April PM Smith David Francell 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bultimore Baltimore Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country)
Marvland **Funeral** 1 X M 2 □ F Hours Min. (Month, Day, Y Director 218-56-2367 58 Usual Residence of Decedent fshow 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director or 28a-f Md. Baltimore City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2nd Fl. or items 23a Funeral 2609 Park Height Ter. 21215 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2. No Specify: Specify: Black 3 Widowed 4 Divorced "natural" Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unknown unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be unknown unknwon unknown Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Anthony Smith/Son 29440 Greenfield Ave., Trappe, Md. 21673 Baltimore, Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Department of Burial 2 K Cremation 3 Removal from State any injury or 04 - 28 - 10Dover, Delaware Direct Crematory Donation 5 D Other (Specify) permit. I 1. Signature / Funeral Service Licensee 22. Name and Address of FacilityBennie Smith Funeral Home 10 516 S. Main St., Hurlock, Md. 21643 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Due to (or as a consequence of) 2 days Stroke disease or condition Medical resulting in death) Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hubertension Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Vear Day Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል abuse Cheroin Cocaine tobace alcohol 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown Records, Polysubstance Completed 24b, Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 1 Yes 2 No filled in by the funeral director, To Be ( 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) pital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 28c Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after deat To the Funeral Director: completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 23, 2010 RES-00 2401 W. Belvedere ave. Baltimore, HD. 21215 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dondlinger Mb Baltimere IVA-RS 32. Registrar's Signature Date filed (Month) State

DHMH 17 Rev 7/2009

Registrar

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1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ loyce a 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner land Hospital Cente George linton Social Security Number 9. Birthplace (State of Foreign 8. Date of Birth **Funeral** 1 M 2 T Months Hours Min. 4-25-1923 VA ountry) 86 226-28-1449 Director Usual Residence of Decedent Show or 28a-f shov se notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director CHARLES WALDORF 1 ☐ Yes 2 X No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 4070 OLD WASHINGTON ROAD 20602 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2√☐ No Specify SpecifyWHITE Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the JEWELRY STORE OWNER TALLEY JEWELERS 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PERCY G. DODSON HATTIE LOVEJOY STRICKLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH E.TALLEY-SPOUSE 4070 OLD WASHINGTON RD. WALDORF.MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAKLAND CEMETERY 4-15-2010WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Luneral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Intra-ahlomi Medical Due to (or as a consequence of) Examiner CERTIFICATION OPPROVED BY MEDICAL EXAMINER Sequentially list conditions Examine if any leading to immedicause. Enter Underlying Due to or as a consultuence of The law requires that the death certificate be executed Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Dav Year signed by the sid be detached if per 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed' this certificate Yes ours after death.

eral Director: After this certific filled in by the funeral director, or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury **Format**, Day, Year) **04/09/2010** 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Unknown 1 Natural 5 Pending 1 Yes 2 X No 2 Accident
3 Suicide Unknown Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Found: 7501 Surratts** 4 Homicide determined Found: Hospital Road, Clinton, MD within 24 hours a To the Funeral L To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completed (Check 3 Gertifying Nurse Fractioners To the best of my knowledge, do 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hitzsh Amin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 11701 Livingston 308 Nashington. Suite 32. Registrar's Sign State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended line 6 per FH/tlv 4/28 Amended of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Q15AM Month Year **Physician** april Linda Lou Thompson 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Fahrney-Keedy Nursing Home Boonsboro Date of Birth (Month, Day, Year) 6/26/1936 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Min. Days Months Hours 73 220-28-3895 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Director Washington MD Keedysville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 5332 Mt. Carmel Church Rd. 21756 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Blue Ridge Outfitters 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Clay Long Margaret Elizabeth Carter ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della Thompson, Sister-In-Law 5332 Mt. Carmel Church Rd, Keedysville Md 21756 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Park Heights Cemetery Brunswick MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bretree John T Williams Funeral Home, Brunswick MD 21716 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a cons quence of Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Be Certification: To

burial-transi and Vital Records, P.O. Box 68760, attending physician I for use as the burial certificate be cate has been signed by the atte page 2 should be detached for a certificate ot Division

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit

**Funeral** 

Director

28a-f show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar is ust be notified as

Department of Health a Important: If item 27 is any Injury or other trau once.

**Physician** 

/Medical

Examiner

Pages 1

"natural", or items

within 72 hours after death with

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Baltimore, Maryland 21215-0036

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		c pregnancy (specify)		Month Day Year					
Part II. Other significant condition	s contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2[	se contribute to the cause of death? ☐ No  3   Probably  4   Unknown					
				24a. Was an autopsy performed? 1 □ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1  Yes 2  PNo	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	G ☐ Other (Specify)					
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) tion	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred					
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		nome, farm, street, factority)	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )						
	Physician: To the best of my kn xaminer: On the basis of examin									

WASEEM KHALID

29b. Signature and title of certifie

1126 DPAL 04-27-2010

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAGERSTOWN MD. 21740

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Ward Townsend 7.400M Medical Facility Name (if not/institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death oce at the ~ak Wicomic ISDUR If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Numbe 8. Date of Birth 1 M 2 X F Months Days Hours Min. 11/29/1918 159-18-5277 91 Yrs Director NJ Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Snow Hill 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 404 Coulbourne Lane 21863 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Completed 3 X Widowed 4 □ Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygienes Important: If item 27 is marked other than any injury or other traumatic event; the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Worcester County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norman Ward Mae Marshall FINIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen White / daughter 7267 Levin Dashiell Hebron, MD 21830 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Trinity Garden of Mem. 4/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Newark, MD 21. Signal of Fun SI Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one dayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BAL POTI disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami and I-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 1 Yes 9 Unknown the a Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 perform 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes HOSPICE ပ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural Natural 5 Pending injury work?
1 Yes 2 No death. 2 Accider
3 Suicide Accident neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined after building, etc. (Specify) within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To this best of my knowledge, death accounted at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHUMM WARES BOX BA5 17

State

Registrar

31. Date filed (Month, Day, Year,

29

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month :46 AM Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Washington Adventist Hospital Tokoma Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) (Month, Day, Yes Funeral Hours Min. Year Country) 1 □ M 2 🕱 F 124-24-9994 89 DC Jan. Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State the Maryland notified at Director 1X Yes 2 ☐ No Temple Hills Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō ral", or items 23a o Funeral with United States 20748 3425 25th Avenue permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner myone. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give þ 21215-0036 African 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed American Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Secretary Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruth Robinson Charles Quarles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 20020 1644 U Street SE Toni T. Lake/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 29, 2010 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lee's Crematory Clinton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 Benning Rd. NE Washington, DC 4001 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Pregnant at time of death ed by the a Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? is certificate has been signed i director, page 2 should be det To Be Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury work?
1 Yes 2 No 1 Natural 5 Pending Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20912 address of person who completed cause of death (Item 23a) (Type, Print) CHININA 7600 Carroll Ave., Takoma Pk, Md.

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Day May 20ÎT Rose G. Voly 21:05 P M Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 Union Hospital Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 D M 2 X F Months Hours Min. Oct. 2, Pennsylvania 1924 Director 222-10-1676 85 Usual Residence of Decedent fshow 10b. County iral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director New Castle 1 Yes 2 No Delaware Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 106 Wallasey Road 19808 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural" 3 X Widowed 4 Divorced White Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President/Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Gaetano Gravino Mary Natalie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Rosemary Czerwinski/Daughter 67 Drift Way, Earleville, Maryland 21919 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Donation 5 Other (Specify) All Saints Cemetery May 11, 2010 Wilmington, Delaware 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Sign ture of Funeral Service Licensee 103 W. Stockton St., Elkton, Maryland 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate signed by the attending physician and be detached for use as the burial-transi Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? this certificate 1 Yes 2 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury\_at After 1 Natural 5 Pending Accident
Suicide Investigation 1 Yes 2 No 24 hours after death Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔲

within 2

State Registrar only one)

30. Name and add

29b. Signature and title of certifier

ess of berson who com

13 2010

of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 24. 2:30 AM M Charles L. Vese1v /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 28225 Vesely Lane Princess Anne Somerset If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 12 M 2 F 09-23-1932 77 068-26-4074 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10h. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Directo MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21853 28225 Vesely Lane USA Funeral 12. Was Decedent Ever in U.S. Armed forces?

1 Yes 2 No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leopold Vesely Jennie Emer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice Vesely/wife 28225 Vesely Lane, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State any Injury or Salisbury Crematory 4/28/2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Hinman Funeral Home 21. Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne. MD 21853 #11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. mediate Cause (Final conquitine **Physician** 3 month \*sease or condition resulting in death) /Medical wal Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 2 No 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

To the Funeral [

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completely

Medical

29a. Certifier

29b. Signature and title of certifier

Brett Hofmann MD

and manner stated.

30. Name and ad ress of person who completed cau i of de in (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30434 Mt. Vernon Road, Princess Anne, MD 21853

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:42A M Norman Wayne Wolfe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1. ★M 2 □ F Days Min. Hours Yrs. Director 220-54-3839 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 E. Washington St. #1015 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 12 Never Married 2 Married ☐ Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked (disabled) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Norman Wayne Wolfe Noami Virginia Hemphill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Stone / P.R. 120 N. Potomac St., Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/10/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications train caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DOOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ certificate has been signed by the atterirector, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Month g Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1∙<del>∏ Na</del>tural 5 Pending 1 Tyes 2 No Accident Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: A within 24 hor To the Fune completed fi

> State Registrar

Medical

Could not be

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist

determined

Suicide

4 Homicide

Janjai

31. Date filed (Month

3 🗆

29b. Signature and title of certifier

29a. Certifier

DIC

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0056413

Hagerstown.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:00 AM SARAH F. WILSON 04/2Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WORCESTER POCOMOKE HARTLEY HALL NURSING Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Hours Min (Month, Day, Year) Director 219-03-2256 96 01/07/14 Usual Residence of Decedent fshow Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho: any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No WORCESTER MD POCOMOKE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 MARKET ST death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 No within 72 hours after Yes Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes. Give 3 Widowed 4 Divorced BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) LABORER DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CORNELIUS FLETCHER JOSEPHINE WHARTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ODESSA JUSTIS - NIECE CYPRESS RD POCOMOKE. MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 Donation 🐧 Dother (Specify) TRINITY U.M. CEM. 05/01/10 POCOMOKE, MD Sign Line | Fune al Service Licensee 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., ACCOMAC, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final DISEASE Physician/ ARKINSON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Day Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been sig page 2 should b 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate ≥ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 A Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4/23/2010 1)0062172

State Registrar

31. Date filed (Month

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1604 MARKET ST

21851

POLOMOKE CITY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ShAZAD & SATYAL, MD 1604 MAZ

32. egistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Month William Mitchell Wood, Jr. lar 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Medica Center La If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 € M 2 □ F Months Days Hours Maryland 78 Yrs. May 31, 1931 217-36-6824 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1∩a State 10h County 1 ☐ Yes 2√☐ No St. Mary's Leonardtown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20650 26400 Point Lookout Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Mae Jones William Mitchell Wood, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22680 Cedar Lane Court, Apt. #1319, Leonardtown, MD Frances Cecilia Wood / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 7, 2010 Helen, Maryland Queen of Peace Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Signature of Funeral Service bicenses P.O. Box 270, Leonardtown, MD 20650 lichaeks 23a. Par 1. Enter the disease, complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. %, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) New UNZ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use confribute to the cause of death? Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 **N**O 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed burial-transi attending physician the for use as the detached cate has been signed, page 2 should be det certificate Hospital or Attending Physician: After this certific funeral director, 24 hours after death filled in by the completely

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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**Physician** 

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after

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Funeral Director

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Be Completed

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Physician/Medical

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Completed

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Certification: To

Medical

within 2 eme

State Registrar

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ON 0

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #191 - State Registrar a, FH, TCHD, 4/27/10, rls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24 Day 04 Onth 2010 CHARLES ELLIOT WHEELER 1:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6785 COOKE'S HOPE ROAD EASTON TALBOT Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min. 93 04718/1917 Director 217-38-4063 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No TALBOT **EASTON** 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o Funeral 72 hours after death with 6785 COOKE'S HOPE ROAD 21601 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Fant: If item 27 is marked other than ury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) LAWYER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ELLIOT WHEELER ADRIENNE TRACY 19a. Informant's Name/Relationship (Type, Print) Jean E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6785 COOKE'S HOPE ROAD, EASTON, MD BETTY J. WHEELER/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it CHESAPEAKE CREMATION 04/27/2010 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MD injury ( 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sylews Immediate Cause (Final Physician, brownsen Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and -trar that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ned f by the signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident within 24 hours after deal To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer

20+IVA RS

State Registrar 31. Date filed (Month APR 2 7 2010

CAROLYN HELMLY, MD

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print)

32. Registrar's Signature B. Jacks

10-01888

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Abe	l William Atle		State of Maryland / Department of 1-For State Certificate of Registrar		lygiene <sub>Reg.</sub>	No. 2010	15083			
Me	Physicia dical Exami		1. Decedent's Name (First, Middle, Last)  Abel William	Allen	2. Date of Death Month E March 6, 20	Day Year 010	3. Time of Death 1122 hrs			
			Facility Name (if not institution, give street and number)     Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly	cation of Death  4c. County of Death  Prince George's					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir	_	(MM/DD/YYYY) 9. Bir -2010 Foreign				
	nd show any ree.	_	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Loca  Uhlsayea				10d. Inside City Limits 1 Yes 2 No			
1	e Maryla or 28a-f	Director	10e. Street and Number	10f. Zip Code 2.352.7	10g	Citizen of What Cou	ntry?			
0	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral D		/as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,			
	ours after o	ā	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decede	Yes 2 No specify:  ont's Usual Occupation (Give kind of most of working life, DO NOT use ret		Specify: Blo				
	0036 within 72 h gene. ner than "n Medical E	Completed	College (1-4 or 5+) WA	_			•			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Menhal Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	To Be Co	17. Father's Name (First, Middle, Last) Mark  19a. Informant's Name/Relationship (Type, Print.)  19b. Mailin	ng Address (Street and Number or	e (First, Middle, Ma		e Zin Code)			
	MD and 2 should be alth and 1 sin 27 is raumatic		hisa Allen - Mother 940	Churchhill Dr.	- 1	ute, Va 2 20c. Location - City or				
	Baltimore, permit. Pages I ar Department of Hee Important: If iter		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition crematory or company or comp	1	Date 2	20c. Location - City or Balto Min	Town, State			
	Balti permit. Departir Imports injury o		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility	ruh Eas	F F.H. Balto, MD	21207-			
-	Physician /Madical		23a. Part I, Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac of			Approximate Interval Between Onset and Death			
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Sudden infant death  Due to (or as a consequence of):	syndrome (SIDS)			-			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
	O,  be executed  rician and  burial - transit	al Exa	events resulting in death) Last  Due to (or as a consequence of):  d							
	60, tte be execut hysician and e burial - tra	Medical	X UNPENDED  AMENDED 23a,27,perME, g903  IF FEMALE:  23c. If yes, outcome of pregnancy	5/17/10 TT		23d. Date of deliver	,			
	that the death certificate oned by the attending phy detached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna other (Specify)	ancy		Day Year			
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	Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l	ompleted			24a. Was an autopsy perform	prior to e	itopsy findings available completion of cause of			
	Vital Recysician: The label bis certificate la director, page	Bec	25. Was case referred to medical examiner?  1 ✓ Ves 2 → No. Hospital: 1 Inpatient 2 ✓ ER/Outpatier	26.Place of Death (Check						
	on of Vit nding Physic th. :: After this e funeral dir	ion: To	1 Yes 2 No 1 inpatient 2 EK/Outpatier  7 Manner of Death 1 X Natural 5 Pending  1 Pending  1 Inpatient 2 EK/Outpatier  28a. Date of Injury (Month, Day, Year)		28d. Describe how	w injury occurred	<del>-</del>			
	Division of piptal or Attending Phous after death.  Teral Director: After tilled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street (Specify)	eet, factory, office building, etc.	28f. Location (Stroor Town, Stat		ral Route Number, City			
	Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	1/9a Centiner . 1							
	- > + 3	¥	29b. Signature and title of certifier  Wy Cu, W.	29c. License number O. C.M.E.		29d Date signed <i>(M</i> o March 7, 2010	nth, Day, Year)			
ار	8 ,		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21201						
	St Regist	ate	31 Date filed (Month, Day, Year) 32. R gistrar's Signature	a. V. I	<del></del>		<u> </u>			

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayonth 1. Mary 10 10 Year 12 15<sub>p</sub> Brice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care N/H N/A Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral**  $\operatorname{\mathtt{Ja}}^{(M^{onth},\ Day,4^{\operatorname{Year})}}$ Country) 1 □ M 2 🖫 F 99 216-14-0112 1911 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1803 Penrose Avenue 21223 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Macone. life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Western Elect Laborer N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Taliferro Thomas Gardner India 19a. Informant's Name/Relationship (Type, Print)
Moses Gardner/Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1433 Madison Ave. Balto., MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem. Pk 5/15/10 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F 21. Signature of Funeral Service Licensee 2700 Edmondson Ave. Balto., MD. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a nonsequence on as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) Day Year led by the a 9 Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 2 X No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, ND 21223 SANDHU 1940 W. BALTIMORT ST. 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ma V 2010 Helmut Н. Beck 7:30 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore 6825 Newstead Lane Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth June 07 Funeral 9. Birthplace (State or Foreign 1 X M 2 - F Days Germany 219-04-7103 73 Director 1936 Usual Residence of Decedent 10a. State 10b. County or 28a-f sho notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore Md. 1 Yes 2 X No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 6825 Newstead Lane 21209 Germany 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural" 3 Divorced 4 Divorced Completed ntal Hygiene. ed other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) International Trader Trading Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bechthold Johannes Α. Beck Emma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6825 Newstead Lane Baltimore, Md. 21209 Mrs. Diedra Beck/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. 5-15-10 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. <sup>22</sup> Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Muneral Mervice Licenses 23a. Part 1. Enter the disease, or complicate ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) VEGVS Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an this certificate has ral director, page 2 performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending ☐ Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

DHMH 17 Rev 7/2009

State Registrar

only one) 29b. Signature and title

iexande 31. Date filed (Month, Day, Year) D 57444

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32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chen

29d. Date signed (Month, Day, Year)

21284

MO

Towson

2010

			Please Type or Print in Bla	ack Indelible Ink. Ensure A / Department of Health and	=	_					
			1 = For State Of Maryland	g. No.2 0   0   15 0 8 8							
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death					
· Lagran	/Medic		Margaret Hofmann Bauermann		May	12 2010 04.02 M					
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h L	4c. County of Death					
	Funeral		Good Samaritan Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. las	Baltimore t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Birthplace (State or Foreign Country)					
	Director		213-32-1963	Yrs. Months Days Hours Will.	July 13,	1934 Maryland					
	yland how			Town or Location		10d. Inside City Limits					
	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show deat Evaning must be redified at	Director	MD Baltimore Timon			1 □ Yes 2 💢 No					
	with the		10e. Street and Number	10f. Zip Code		g. Citizen of What Country?					
	death ms 23	Funeral	205 Belmont Forest unit 207  11. Marital Status 12. Was Decedent Ever in U.S.	21093  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		SA  14. Race - American Indian,					
98	after or ite	y Fui	1 Never Married 2 M Married Armed Forces?  1 Yes 2 M No If Yes, Give	If Yes, specify Cuban, Mexican, Puert  1 □Yes 2 ☑No Specify:	to Rican, etc.)	Black, White, etc.  Specify: white					
9	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Decedent's Usual Occupation	1.	6b. Kind of Business/Industry					
21215-0036	within ene. than '	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)  Omemaker		Own Home					
pu	be filed vital Hygid d other event, It	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, M.						
Maryland	es 1 and 2 should be for Health and Mental fitem 27 Is marked or other traumatic ever	၀	J. Henry Hofmann		t Murphy	City on Town Others Tip Code)					
	nd 2 sl alth an 27 Is i		1 - 4	19b. Mailing Address (Street and Number or Ru 205 Belmont Forest ui		Timonium, MD 21093					
Baltimore,	ss 1 ar of Hec litem rothe		20a. Method of Disposition 20b. Place	te of Disposition (Name of petery, crematory or other place)		Oc. Location - City or Town, State					
ii ii	Pages tment of i tant: If its jury or o		IX Burial 2 Li Orgenpation 3 Li Removal from State		/2010 T	owson, MD					
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Fun (r) Service Liven /	22. Name and Address of Facility	3 U Y	1050 York Road					
			23a. Part 1. Enter the disease, or complications the caused the death.	Ruck Towson Funera  Do not enter the mode of dying, such as cardiac		st Approximate					
	hysician		shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition	neic Respirator	v Ac co	Interval Between Onset and Death					
4	The law requires that the death certificate be executed WEN are has been signed by the attending physician and magge 2 should be detached for use as the burial-transit of the control of		Du to or as a conse Nince of):								
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  CONGESTIVE HEAVY FAILURE								
		Examiner									
		_	resulting in death) Last Due to (or as a consequence of):								
9289		dica	d								
Box (		n/Me	IF FEMALE: 23c. If yes, outcome of pregnance			23d. Date of delivery					
O. B	the atte	Physician/Medical	in the past 12 months?  1  Yes 2 No 9 Unknown			Month Day Year					
<b>.</b>	iician: The law requires that the of certificate has been signed by the rector, page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?					
rds	quires en sigr uld be	Completed by	Coronary Artery	1 ☐ Yes	☐ Yes 2 ☐ No 3 ☐ Probably 4☐ Unknown						
ဝ၁	law re las ber 2 sho	plet	Hyper tehsion, C	Desity	24a. Was an autopsy						
al B	icate h			/	perform	death? □No 1 □ Yes 2 □No					
Vit	Physician: r this certific ral director, r	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF	s)							
10	ig Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28	8/Outpatient 3 □ DOA	28d. Describe hov	nce 6 Other (Specify) w injury occurred					
sior	Attending or death. ector: After by the fune	catio	Natural 5  Pending (Montin, Day, Year)  2  Accident investigation  3  Suicide 6  Could not be	M 1 Yes 2 No							
-	or Att after d Direct d in by	Certification:	4 ☐ Homicide determined determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Stre City or Town,	(Street and Number or Rural Route Number, wn, State)					
	In the Nospital or Attending Physician: The Within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occu	e, and due to the ca urred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)					
		Mec	29b. Signature and title of certifier,	29c. License number	29	d. Date signed (Month, Day, Year)					
	To the within 2 To the complet	-									
	ro the within To the compl		Jall MD	Res O	00 0	05/13/2010					
	Io the within To the compl	~	30. Name and address of person who completed cause of death (Item 2: ZAFI ABOU ZAHR 560)			05/13/2010					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear Physician 100 AM Elizabeth M. Byrne 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSDITA Balt enes  $\widehat{\,}$ mo N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day Year) 12/19/1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 🗗 F 78 Maryland 215 28 9682 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 1 ☐Yes 2 1 No Director Ferndale Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21061 Funeral 241 Williams Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 10. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill ent of Health and Mental H it: If Item 27 is marked oth y or other traumatic eventy Be Julius Dietz Ethel Scarborough ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Byrne / Daughter 241 Williams Road Ferndale, Maryland 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Iter
any Injury or ott 1 Burial 2 Cremation 3 Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MD State Veteran Cem. 05/14/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 23 . Part 1. Enter the disease of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 dai /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1 □ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: ₱ 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore nam land 900 Avenue ИИ 32. Regis rar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10Day MAY 201°0 Marion Rollins Beasley 11:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Asbury Methodist Village Gaithersburg Montgomery 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 1 🖟 M 2 🗆 F Hours (Month, Day, Year) JUL 8, 1919 South Carolina 248-12-5755 **Director** Usual Residence of Decedent 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 No Maryland | Montgomery Gaithersburg Ö ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23aFuneral United States 20788 407 Russell Ave #416 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₽ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. WWII 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Office of the Security of Defense Elementary/Seconday (0-12) College (1-4 or 5+) 4 Personal Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Tillman Smith Beasley May Rollins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 Woodbine St., Alexandria, VA Karen S. Beasley/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory May 13,2010 Beltsville, MD 22. Name and Address of Facility & Cremation Services 833 Gist Ave., Silver Spring, MD M00982 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Pnysician/ Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Health 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Care Cntr 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one) 29b. Signature and title of

31. Date filed (Month, Day,

Steven Dolinsky, M.D.

DHMH 17 Rev 7/2009

oh

32. Registrat's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D20148

911 Russell Ave. Gaithersburg, MD 20788

29d. Date signed (Month, Day, Year) May 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4a. Facility Name (if not institution, give street and number) 2010 Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saltimone Social Security Number If Under 24 Hrs. n vrs. last birthday If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 F 79 Months Days Min. (Month, Day, Year) Aug 04 Country) Maryland 212-28-6116 Yrs 19‡0 Director Usual Residence of Decedent 28a-f shor 10a. State 10b. County death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2910 Andorra Ct. Apt. E United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 e filed within 72 hours after 1 Yes 2 No Specify: Specify. "natural" Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Aikens White Anna Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Charles Brown /Son 2910 Andorra Ct. Apt. E Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date May 20c. Location - City or Town, State it. Page 1 cartment of ortant: If i 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland injuny 4 Donation 5 Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Nameand Alternatives Der Imp any 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ethysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. o as a consequence of rany, sading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year by the detached g Unknown g Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier May 10,2010

Registrar

State

Enankin

Square Drive Battimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year MARY E. BOOTHE 0055AM 13 0105 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner are Hospital Center ROSedale If Under 1 Year | If Under 24 Hrs. Baltimor FRANKLIN SQU 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
May 30,1934 **Funeral** 1 M 2/CKF Months Days Hours Min 75 215-32-8685 Director Maryland Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location 27 is marked other than "natural", or items 23a or 28a-f show or traumatic event, the Medical Evandrat must be notified at Director 1 ☐ Yes 2 🙀 No Marvland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21221 USA 313 South Taylor Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ X No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc 1 ☐ Never Married 🗶 🛛 Married 21215-0036 1 □Yes 2 No Specify <u>გ</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. Sales Clerk Dept. Store Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be 1 Health and Mental Ruth E. Johnson Bruce W. Knauf ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 South Taylor Avenue Essex, Md. 21221 Department of Health Important: If Item 27 any injury or other trong. Woodrow Boothe (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Church Cemetery 5-15-2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. on ture of Funeral Service Licensee 22. Name and Address of Facility al Home Loutto 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HCUTE Coronary Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner oronary Sequentially list conditions, it my, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Ye ar Day 5 Other (specify) P.0. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 100 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

W

T

BOOTH

DHMH 17 Rev 1/2001

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

DR Heather

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mancebo

32. Relistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES0000

9000 FRANKLIN SQUEETE DR Balto

29d. Date signed (Month, Day, Year)

21237

5/ 13/10

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 11:55 M **Physician** Мау William Patrick Burke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 340 Magothy Beach Rd. Pasadena Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 ☑ M 2 ☐ F 57 Yrs 579-70-2252 Director 1952 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show int or other traumatic event, I'm Medical Experient of use the mathed at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 340 Magothy Beach Rd. 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ∑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1∐Yes 2⊠No Specify Specify: ş White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bio-Science Technican Horticulture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Η. Burke Lucy 2 Rhine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly K. Burke (Spouse) 340 Magothy Beach Rd. Pasadena, Md. 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 5/13/10 Baltimore, Md. 22. Name and Address of Facility Stallings Funeral Home PA re o Funeral Scrvice Licensee 3111 Mountain Rd. Pasadena, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each time. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? aw 24a. Was an autopsy performed? 1 Yes 2 No certificate 2 **X** No 1 ☐ Yes Physician: After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient 5 Residence 6 ☐ Other (Specify) Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Reg Date filed (Mont State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	•	artment of H tificate of L		and Me	,	giene Reg. No2	0	15094
	Physicia Medic		1. Decedent's Name (First, Middle,	Last)		Bo	unds		١.	2. Date of Dea Month	ath Day ZO	Year	3. Time of Death A
	Examin		4a. Facility Name (if not institution, Mevcy Heal)	ical cont	w		4b. City, Town, or Baldow	ne	of Death	y	4c. County	of Death	
	Funeral Director		218-54-3274	6. Sex 1 □ M 2 🏋 F 63	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		B. Date of Birt Aug 15	<sup>h</sup> , Year) 946	9. Birthp Count	place (State or Foreign try) MD
	aryland a-f show fied at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Howar	d		, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	rith the Ms 23a or 28 st be noti	Funeral Director	10e. Street and Number 10162 Placid	Lako Court			10f. Zip Code 21044				10g. Citizen of W	hat Coun	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status  1 □ Never Married 2 □ Marri 3 □ Widowed 4 ☒ Divorced	12. Was Decedent & Armed Forces?		ŀ	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🚺 No	ın, Mexica	ın, Puerto Ri	fy Yes or No- can, etc.)	14. Race	, White, e	
Baltimore, Maryland 21215-0036	within 72 hour giene. er than "natu , the Medical	Completed	15. Deceden (Specify only higher Elementary/Seconday (0-12) 10	t's Education	+)	(Give i life. D	lent's Usual Occup kind of work done of NOT use retired) Dunselor	ation during mos	st of working	,	16b. Kind of Bu		rd County
/land	2 should be filed th and Mental Hy, 27 is marked oth traumatic event	To Be	17. Father's Name (First, Middle, La James Seal	ast)					,	First, Middle, Cocke	Maiden Surname) Y	ı	
, Man	d 2 shoule alth and hard in 27 is meen trauma		19a. Informant's Name/Relationsh Mr. Scott Bound				ng Address (Street o						Code)
more	Page 1 ar nent of He ant: If iten ıry or oth		20a. Method of Disposition 1 ∰Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Ce	metery, cren	sition (Name of natory or other place Memoria	ээ) 1	5-17-		20c. Location - Sykesvil	•	·
Balti	permit. Departn Importa any injt	1	21. Signature of Funeral Service Li		r F		Name and Addres					ne &	Chapel
	Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  a. Die to (or as a consequence of):										
)·	be executed sician and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. imjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):										
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  □ Yes 2  No 9  □ Unknown	23c. If yes, outcome of 1 Live Birth 24 Pregnant at 9 Unknown	2 🗀 Fetal	death 3	Ectopic pregnand Other (specify)	су			23d. Date Mor		ery Day Year
ls, P.O	uires that the signed by all the deta		Part II. Other significant condition	ns contributing to death but	not resu	ilting in the u	nderlying cause giv	ven in Part	t I.	23e. Did to	1-0	_	e cause of death?
Records,	he law requ te has beer age 2 shou	Completed by		***			-				rmed? p	rior to cor eath?	osy findings available mpletion of cause of
Vital	ysician: T s certifica director, p	To Be C	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \begin{align*} \tilde{\chi} \t	Hospital:	nt 2 🗆 I	ER/Outpatier	l Out	or.	ath (Check o	nly one)	lence 6 🗆 Other		-1
Division of Vital	nding Phy ath. r: After thi ie funeral	Certificate: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig	28a. Date of injur (Month, Day,	у	28b. Time of injury	28c. Injun work	y at	28		ow injury occurre		
Divisi	tal or Atters after de al Directo									Route Number,			
	the Hospit in 24 hour the Funer apleted fill	Medical	(Check 2 Medical Ex	Physician: To the best of r xaminer: On the basis of ex Nurse Practioner: To the b	amination	and/or invest	igation, in my opinio	on, death o	occurred at th	ne time, date a	nd place, and due	to the cau	use(s) and manner stated.
	To t To t		29b. Signature and title of certifier	A. Has	el,	10	29c. License	number	4		29d. Date signed	(Month, E <b>3,</b> <i>U</i>	Oay, Year)
	4		30. Name and address of person v	who completed cause of de	eath (Item	23a) (Type, F	rint)	Les	301 B	St. Valtin	and i	place	1201
	Stat Registra		31. Date filed (Month, Day, Year)	2010 Persua	r's Signati	Bo	M				•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gwendolyn Marie Bartlett 2010 7:50 A 13 Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Year) Mav 1, 1950 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Months Hours Min. Maryland Director 217-56-8964 60 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21222 8354 Bletzer Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Was Deceue... 2... Armed Forces?
1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Manager Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry August Hensler Elizabeth Thelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9110 Avenue C., Edgemere, Maryland 21219 Stacy Casey Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Sacred Heart of Jesus Cem. May 17, 2010 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Synature of Huneral Service Licensee, Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancu disease or condition resulting in death) ung yeurs Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Ectopic pregnancy Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be Completed 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? Yes 2 🔼 No 2 🗌 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 X No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending after death. work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical

State Registrar

To the vithin 2

Box 68760

Records.

Division of Vital

29a. Certifier

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Gran

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

N.

Charles

32. Registrar's Signatur

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Towson,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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21204

29d. Date signed (Month. Day, Year)

May 13, 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month\_ Day Year BRILL 0500M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL WESTMINSTER CARROLL COUNTY HOSPITAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 11172071924 Country) MD 219-12-8302 85 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 2511 ARABIAN COURT 21048 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify WHITE Specify: 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** SUBSTITUTE TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic eve t. Page 1 and 2 should be fill thent of Health and Mental tant; If item 27 is marked NUSINOV **EDITH** CHARLES LENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL B. SERIO/SON 826 UNIONTOWN ROAD, WESTMINSTER, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 母性最高的 or other place) MEMORIAL GARDENS 20b. Pla 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5/12/2010 FINKSBURG, MD Bonation 5 ☐ Other (Specify) Signature f Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Adeno carein um a Ph sician/ Mera static disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SWOCK Dentic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) Pregnant at time of death in the past 12 months? Month been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by stemosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s \_ 2 🗓 1 Yes 2 INO 25. Was case referred to medical examiner?

1 \( \text{Yes} \) 2 \( \text{No} \) No 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe

State Registrar 31. Date filed (Month, Day, Year)

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

MO

39502

4021157

447, East Main sheet

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY TT 10:05 P M DAVID A BULMASH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BLAKEHURST ASSISTED LIVING TOWSON BALTIMORE Social Security Number 6. Sex 1 M 2 D F Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours 1272471916 93 215-07-3514 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No MD TOWSON BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 WEST JOPPA ROAD, #445 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ BULMASH MOLLY STEINBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1055 WEST JOPPA ROAD, #445, TOWSON, MD 21204 ANNA BULMASH/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State BETH EL MEMORIAL PARK 5/13/2010 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheinus disease or condition Lows Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Physician/Medical Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? Month 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown completed filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗖 No Hospital Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R149194 May 12, 2010

Registrar
DHMH 17 Rev 7/2009

State

Towson

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Grant

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(harles

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $11^{\text{Day}}$ ΜÂΨ 20**10** 04:38Р м **EUGENE** BERGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 XM 2 - F Months Days Hours 01/22/1925 MD Director 216-16-3865 85 Usual Residence of Decedent shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director OWINGS MILLS 1 🗌 Yes 2 🗶 No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21117 4730 ATRIUM COURT, #379 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES ADVERTISING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BRAVE **BERGER** KOPEL RACHEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELENE BERGER / WIFE 4730 ATRIUM COURT, #379, OWINGS MILLS, MD 21117 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP. 05/14/2010 TOWSON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) DAYS Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine PULMONARY HYPERTENSION and I-transit MONTHS that initiated events resulting in death) Last burialattending physician Physician/Medical EARS Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Scapped at time of death

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completed filled in by the funeral director, page 2 autopsy performed' Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔁 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MO 6701 NCHARLES ST, SUITE 4105 BALTIMITE, MS 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DOROTHY D. BARCZAK 6:00 P.M MAY 10. 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death OAK CREST CARE CENTER BALTIMORE PARKVILLE 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □**X**F Months Days Hours Min. Director 217-54-9319 11/2/1916 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 Yes 2 XNo BALTIMORE PARKVILLE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 8820 WALTHER BLVD. #4216 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: Specify: 3 ♥ Widowed 4 □ Divorced WHITE or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10TH GRADE HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ARTHUR F. BLOTTENBERGER MARIE KUHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY DELUCA/DAUGHTER 2306 KNOLL COURT JARRETTSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BEL AIR MEM. GARDENS 4 ☐ Donation 5 ☐ Other (Specify) 5/14/2010 BEL AIR, MD 21. Signature of Funeral Service, Ligensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO1139 8521 LOCH RAVEN BLVD. TOWSON. MD 21286 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Oncet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ page 2 should be detached for in the past 12 months?

1 Yes 2 No Pregnant at time of death
Unknown Month Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work 2 No Investigation 6 Could not be 3 Suicide Place of İnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Mdnth, Day, Year) 043580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTHER BLUD. BALTO. 8830 STINE 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Russell J. Christopolus 3:00 0. CLA 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town\_or Location of Death 4c. County of Death Examiner N/A NURE Social Security Number If Unde 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 55 Months Days Hours Min. 220 60 8906 Maryland Director 06/07/1954 Usual Residence of Decedent works } 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified Director Maryland Baltimore Lansdowne 1 Tyes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 Tionesta Road 3A 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 5-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🗓 No Specify Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Warehouseman Loews 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be and Mental Chris Christopolus Virginia Leake P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Hammonds Ferry Road Nikolaos Christopolus / Son Baltimore, Maryland 21227 Item 2 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 ō = ŏ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 05/12/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Kin muccus 23a. at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart findire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** - MI went woo day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate Vital 1 Tyes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 A No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) 9005 CATON Ave MD 2/229 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

DHMH 17 Rev 1/2001

10-03560 Anthony Crist Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day Month 1805 hrs May 8, 2010 Medical Examiner Anthony Crist 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 520 N. Collington Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Country) MD Hours Months Director 42 05.19.1967 1 M 2 F Yrs UNK Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No s 23a or 28a-f show a notified at once. Baltimore hours after death with the Maryland MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö N. Chape] Street 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 No Yes swhite 1 Yes No specify: If Yes, Give Year 3 Widowed 4 Divorced "natural" ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Automotive Detailer 21215-0036 Compl rtant: If item 27 is marked other i 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul Bernard Crist

19a. Informant's Name/Relationship (Type, Print) Katherine Rust 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Fallston, Trinity Place, MD2403 Stacey Guzman/Sister 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) Burial 2 Cremation 3 Beltsville, 05.12.10 Important: Chesapeake Crem. Donation 5 Other Specify 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, PA 21. Signature of Funeral Service License 717 Green Pastures Dr. BAlto. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death /Medical a. Gunshot Wound of Torso Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical **AMENDED** UNPENDED the attending physician ed for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year 1 Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions <u>о</u> signed Yes 2 V No 3 Probably 4 Unknown ğ Completed Records, icate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No ✓ Yes certificate 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 Yes funeral 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d Describe how injury occurred 28b. Time of Injur After 27. Manner of Death Subject shot Certification: FOUND: Yes 2 ✔ No Division Natural Pending within 24 hours after death. To the Funeral Director: Director: May 8, 2010 1756 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 520 N. Collington Avenue, Baltimore, MD determined (Specify) Back yard 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 9, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

TE ATE

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 15 102 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 5 2:15A M Carole S. Castronuovo Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days Dec 27 1 M 2 X F Hours 1945 Unknown 215-44-4606 Director 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Washington, 10e. Street and Number 10a. Citizen of What Country? items 23a Funeral 1876 4th Street NE 20002 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ò þ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 No Specify. "natural", 3 ☐ Widowed 4 ☐ Divorced Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip J. Blair/Friend 1518 Kearney St. NE #304, Wash, DC 20017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/10 Chesapeak<u>e Crem</u> Beltsville, MD Signature of Eugeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home M00996 3821 14th Street NW, Washington, DC 20011 Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Carcinoma of Uterine Cervix disease or condition resulting in death) year Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical death certificate be the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy rmed? death? 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes hours after death. meral Director: A 2 No the f ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/5/2010 D39979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 1400 Forest Glen Rd. #435, Silver Spring, MD 20910

State Registrar William K.

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

**ORIGINAL** 

Kelly,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7.20 A M COX DAVID 05 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care - Rossville Rossville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 № M 2 🗆 F 217-26-1182 Director 90 7,1920 May Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant: If Hem 27 is marked other than "natural"; or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 2 No Director 10q, Citizen of What Country? 10f. Zip Code 10e. Street and Number 327 Essex Avenue 21221 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plant Security GM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander M.D. Cox Emaline Rutherford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s.
Department of Health ar
Important: If Item 27 is
any Injury or other traus 301 John Harrison Road Harwood MD 20776 Larry D. Cox 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/13/10 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto.MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 70 Jesson. disease or condition resulting in death) /Medical Due to (or as a consequence of): Ėxaminer Renal Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Dem the burial-tran and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the n signed by tl Id be detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Be Completed Frallation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 146 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completely

(Check only

SHOA113

31. Date filed (Month)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAB (HMI MD)

32. Re

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31464

SZI N. EUTAWST SMIK 300 BALTIMORE MD 21201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 1:35 PM Lawrence Case 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Days Hours Sept 4, 1929 Mary Tand Director 213-24-9149 80 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21218 USA 3401 Greenway #401 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☑ Yes 2 ☐ No 1954—

If Yes, Give 1956 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc "natural", or þ 1X Never Married 2 ☐ Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation un 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 6 social worker e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward William Case Christa Irene Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Vann Edwards/nephew PO Box 93; Pinehurst, North Carolina 28370 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signatury of Fineral Service Licensee 22. Name and Address of Facility Board; 655 W. Baltimore Street irector Baltimore, Maryland 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury sician and bunial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 🗌 No 9 Unknown Division of Vital Records, P.O. ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown Completed 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? 2 XNo Other: မ 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month; Day, Year)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 519110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Carpenter Mai *1533* M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO SALISBUL THINSUUD PATE 8. Date of Birth (Month, Day, Sept 24 Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 9. Birthplace (State or Foreign **Funeral** Year] 19<u>39</u> 1 🖾 M 2 🗆 F Months Days Min. Hours Maryland 70 Director 219-26-4444 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 ☐ Yes 2 😾 No Crisfield Somerset 10e. Street and Number 0f. Zip Code 10g. Citizen of What Country? Funeral 21817 USA 3143 Calvary Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛂 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry un Elementary/Seconday (0-12) College (1-4 or 5+) 8 carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Frances Mary Doddy John Lee Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3143 Calvary Road; Crisfield, Maryland 21817 19a. Informant's Name/Relationship (Type, Print) Linda Hughes/POA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Sign ture of Funeral Service Ronal State Anatomy Board; 655 W. Baltimore Street Raltimore, Maryland 21201 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a. Part I. Enter the disease, or complications shock or heart failure. List only one cause Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): . Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Fa To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No Probably 4 ☐ Unknown 1 Yes Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 🗙 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 XNo ည 1 Tyes 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural work? 1 🔲 Yes 5 Pending in 24 hours after deam.
The Funeral Director: Aff 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif 29c. License number Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) SAlisbury Md. 2180

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 James May 6:20 P M Davis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday)

Director 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 0 Maryland 21215-0036 "natural" and Mental Hygie is marked other

**Physician** 

/Medical

Examiner

**Physician** /Medical Examiner

Saltimore,

Box 68760,

P.O.

Division of Vital Records,

Pages 1

the death certificate be executed burial-1 physician the attending pl detached signed t page Hospital or Attending Physician: director funeral After death.

5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 → M 2 □ F 76 262-46-4255 Feb. 12, 1934 Florida Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Hvattsville 1 ☐ Yes 2XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4922 LaSalle Rd. 20782-3302 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No ģ Specify. Specify: Black 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Automotive (Detailing) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be D. Davis Nancy Hotten ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauonce. Toni Stewart / Niece 936 N.W. 164th Ave., Pembroke Pines, FL 33028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory | 5/8/2010 Beltsville, MD 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility
Rapp Funeral and Cremation Services Rapp Funeral and Cremation
933 Gist Ave., Silver Sprin
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death ANTERIOS CLE NOTIC CAPIDIOVASWAS Immediate Cause (Final GORIS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Discust 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Peripheral Antenese Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform LEFT BOON KNEE GIMPU testion 2 🗆 No 2 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Undedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) [ Lucenshing Rd Hightsu: 1/2 MID 20181

State Registrar

within 24 hours after deatl To the Funeral Director:

31. Date filed (Month, Day,

M) 4203

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Davi 5 5:41 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 5. Social Security Number of Maryland Medical N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** .Sex 1X M 2 □ F 8. Date of Birth (Month, Day, Year, 26.19 Months Country) 219-32-9491 **Director** 1937 Feb. Marvland Usual Residence of Decedent or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2437 Etting Street 21217 USA 'natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Black Specify: 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 9th Grade Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Davis, Sr. Georgiana Dancy permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Davis/ Brother 2018 E. 31st Street Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt. Zion Cemetery 5/19/10 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service Licenses 4210 Belair Road Baltimore, 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pitysician Septicemia disease or condition Medical resulting in death) Due o (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): or Attending Physician; The law requires that the danth certificate be executed and Due to (or as a consequence of): resulting in death) Last the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for 5 Other (specify) Month Day Vear Pregnant at time of death Yes 2 No detached 9 Unknown 9 Unknown by 1 s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidny disease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Alzheimer's disease page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital 1 🗌 Yes Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury accurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ate Gibson Greene St. Bultimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8&20b, perFH, G904, 6/23/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 10:46 AM May 10, 2010 Mary Ellrod Philomena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Spring House Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Months Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 91 NOV. Director 068-16-6772 1918 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic excess. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director VA Fairfax Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA
14. Race - American Indian, 12469 Lee Jackson Memorial Highway 22033 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 🔀 No 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Substitute Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Iannotti Laura Ray ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Ellrod - Son PO Box 240, Granby, CT 06035 20b. Place of Disposition (Name of cemetery granatory or other place)

Glenwood/St. Patrick

Brookside Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial \_ 2 ☐ Cremation 3 ☐ Removal from State May 26,2010 4 Dopation 5 Dother (Specify) Watertown, NY 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility
D.L. Calaro Funeral Home 135 Keyes Ave., Watertown, NY 13601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** <sub>a.</sub> Cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Dementia and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 Tes 2 No 3 Probably 4 Unknown Completed Diabetes Mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 X No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No P After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🛚 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 11, 2010 D69800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Rd., Rockville, MD 20850 Tao Yum, M.D. 31. Date filed (Month, Day, Year) 32 egistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** Violet Lilly Eckert Year 15 Tay 2010 /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner If Under 1 Year 6. Sex If Under 8. Date of Birth (Month, Day, Year) 04/01/1914 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days 96 Maryland 219-50-4283 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21224 "natural", or items 23a 7906 Bank Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 · by 1∐Yes 2**X2X**No Specify: White 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F pe Frances Adel Kammerzell Albert Peter Hagen Pages 1 and 2 should Health and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4421 Caldwell Square, Belcamp, Maryland 21017 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau
once. David Eckert (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Eurial 2 ☐ Cremation 3 ☐ Removal from State 05/15/2010 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bruzdziński Funeral Home, P.A 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disc 15e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or art failure. List only one cause on each line. Conna Immediat Cause (Final diseas r condition resulting in death) **Physician** Year /Medical Due to (or as a conse Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence or cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be execu-Due to (or as a consequence of): P.O. Box 687606 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) detached 9 Unknow been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed' 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation r death. 1 □Yes 2 □ No filled in by the within 24 hours after deat To the Funeral Director; 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: 10 the basis of examiner: On the basis of examiner and manner stated. completely 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who

State Registrar FIL SUL

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phyllis Month A Ebberts 2010 Jane 40 K M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death JIMOFE WASHINGTON MEDILAL CE CLEN BURY HRUNDEL ANME JI€ If U 7. Age (In vrs. last hirthday nder 1 Year I if Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days (Month, Day, Year) Jan. 18 Months Hours Director 220-16-0362 Country) 83 Yrs. 1926 MD Usual Residence of Decedent show Ħ 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 Tes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 313 Hospital Drive 21061 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Black, White, etc à 1 Never Married 2 Married ☐ Yes 2 ☑ No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify. "natural". Completed 3 Widowed 4 Divorced Specify White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event injury or other traumatic event injury event event injury event event injury event Elementary/Seconday (0-12) College (1-4 or 5+) 10 Security Guard Government Court House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Lew Margaret Boward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Elaine Ebberts (daughter) 34977 Keelson Street, Millsboro, De 19966 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 06 May Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 0.121. Signatur of Funeral Service ense 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ MYOLARDIA disease or condition Medical resulting in death) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit HROHIC ルグノイア and that initiated events resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death be detached 1 ☐ Yes ∠ = 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy death? yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ė Hospital 1 Tes 2 🗷 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Manne f Death Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred Accident Natural 5 Pending 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu d title of ce 29d. Date signed (Month, Day, Year) 15 45149 d address\_of person who impleted cause of death (Item 23a) (Type, Print HOS 31. Date filed (Month, D 2. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear terrei 3:50 AM forma Ma 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Harbor Hospital Center Baltimor N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛂 F Days 05/01/1945 65 Maryland Yrs Director 214 44 3596 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h Counts death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Glen Burnie Maryland 10e. Street and Number 10g. Citizen of What Country? 6412 N. Centennial Place Apt. D 21061 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. þ 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mercy Medical Center 12th Admitting Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nora Larsen Robert Herget 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Raymond Ferrell Jr. 6412 N. Centennial Place Apt D Glen Burnie, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park: 05/13/2010 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the discusse, or complications that caused shock, or heart failure. List only one cause on each line e, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 40 condial Medical Due to (or as a nsequence of) **Examiner** etastal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician and is the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death jo Pregnant at time of death Month Day Year detached the g 🗌 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β pertension 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed ordemia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes 2 No 1 Yes 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined thin 24 hours a the Funeral C Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Javzandulam Natsag RESCOI 2010 nd address of person who completed cause of death (Item 23a)

Registrar

State

300

31. Date filed (Month, Day, Year)

Hanover

32. Regist ar's Signature

Street

2/225

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Month Year Day 18:10 OF Medical 910 **Examiner** or Location of Death 4c. County of Death talti More 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the May/and Department of Health and Mental Hygiene.

In the May are the marked other than "nothing or other than "nothing". item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 🗆 Yes 2 🗙 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mr. Kim 21202 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📈 No Specify: If Yes, Give Year or Dates 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Be ပ 20b. Place of Disposition (Name of crematory or other place Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arre Immediate Cause (Final Onset and Death Ph sician/ Anoxic braun disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Chole ey stit is that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Month Day signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျ 1 🗌 Yes 2 No Other: 1 KInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 Accident
3 Suicide
4 Homicide 1 \sum Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD AT 243 894686 05,10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Parkway East 201 Universit Janue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Vear Physician/ 246 AM Joseph L. Freyer 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor FRANKLIN SQL eda icere 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Funeral (Month, Day, Year) Days Hours Min. 1 🖾 M 2 🗆 F 220-20-2242 81 Director July Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland notified at Director Baltimore 28a-f MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò traumatic event, the Medical Examiner must be Funeral items 23a 4130 Cliffvale Rd. 21236 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. 2 □ No 1951-Š 1 Never Married 2 Married X Yes "natural", or Maryland 21215-0036 white 1 ☐ Yes 2 🗓 No Specify: If Yes Give Specify: 1953 Completed 3X☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha printing pressman 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Thema Hales þe John Albert Freyer Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Cliffvale Rd.; Baltimore, Maryland 21236 <u> Christopher Freyer/son</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) <sup>22, Name and Address of Facility</sup> State Anatomy Board; 655 W. Baltimore Street 21. Signature of Funeral S Baltimore, Maryland 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal arrhythmia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Arter diseas orona Sequentially list conditions, Due to for as a conseque If any, leading to immediate cause. Enter Underlying Examir Atherosclerosis Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last and-trar Due to (or as a consequence of) attending physician a for use as the burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the Unknown 9 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? 1 Yes 2 No certificate 2 - N Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Tyes 2 No ည within 24 hours after death.

To the Funeral Director: After this funeral ( 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 only one) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) md Pipkin 9000 Franklin Square 13 Balto DR DR MIChael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

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AMEND ITEM#15,16b,20a-c,22perFH,G903,5/25/2010,WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Nc. 2 1 - 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month May 6<sup>Day</sup> 20<sup>Year</sup>0 10:00 John Gladden  $A^M$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Min. March 3, 1 ፟M 2 □ F Washington DC 1934 577-46-9222 76 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director Forestville MD Prince Georges 1 Yes 2 No 28a-f 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò pe Funeral 'is marked other than "natural", or items 23a raumatic event, the Medical Examiner must b 7420 Marlboro Pike 20747 USA permit. Page 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner muonce. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 X No Specify: black Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Private CVS-Pharmacy Elementary/Seconday (0-12) unk. stock clerk <del>-unk-</del>9th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Francis Gladden Blanche Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3511 Texas Avenue SE; Washington, DC 20020 Belinda Nelson/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State ee's Crematory May 19,2010 Clinton, Maryland 22 Name and Address of Facilitistewart, Funeral Home, Inc. 4001 Renning Rd NE Washington, DC 20019 Simplifie of Funeral Salice Licenses rector 100 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atute Myocardial Intaction Physician/ disease or condition resulting in death) Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the s should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 6th MAY 2010 D0055120 2 Name and addresporperson who completed cause of death (Item 23a) (Type, Print) avenue SE Sinte 310 Washington DC talmen 1328 Southern 31. Date filed (Month, Day, Year) 32. Regis

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State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G903, 5/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Month Physician/ Gary Donald Hephner May 730p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lusby Calvert 12999 Rousby Hall Rd. 8. Date of Birth (Month, Day, Yes .Tune 15 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

D.C. **Funeral** 1 🙀 M 2 🗆 F Days Hours 230-46-0598 72 Director 1938 Usual Residence of Decedent l Hygiene. other than "natural", or items 23a or 28a-f show ownt. the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Funeral Director MD Calvert Lusby 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12999 Rousby Hall Rd. 20657 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: 3 Widowed 4x Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Cab Driver 12th N/ABe 18. Mother's Name (First, Middle Harider Sumame) 17. Father's Name (First, Middle, Last) ဂ္ Winifred Whiham Donald Joseph Hephner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12999 Rousby Hall Rd Lusby, MD 20657 Jeanene Brinkley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey 5/14/10 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charisse N. Woods F?S 2700 Edmondson Ave. Balto., MD 21223 Signatur Funeral Service Licensee 2700 Edmondson Ave. Balto., MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Periphera Years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cerebrovarcular Accident 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performed? 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D54346 SC Gally 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANDRA SAJJA, ROAD, 24035 THREE NOTCH MD 20636 HOLLYWOOD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAY 14 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 700 2010 Medical cility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hills Nursing Montgomer Whea Home 8. Date of Birth 7. Age (In yes. last birthday) If Under 1 Year If Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 M Months 91 217-04-Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shore must be notified at irector 1 Nes 2 No MD Montgomer th ۵ 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral Korea item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mus Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 filed within 72 hours after 1 🗆 Yes 2 🗐 No ASIam Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) omes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name (Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau mD 20878 atinum 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) re of Fineral Service Licer Sign 22. Name and Address of Facility 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lostridium 1 Yes 2 No 3 Probably 4 Thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina injury Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of

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State Registrar egistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 George Washington May 8 Hatten 11:52 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Prince George's Hospital Center Chever1v Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 X M 2 D F Months Days Hours Min Oct. 5, 1917 Director 226-16-7572 92 Virginia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director Marvlana Prince George's Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 318 Tamarack Court 20774 U.S.A. within 72 hours after death 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Norfolk Navai Shipyard other t Shipyard Be 17. Father's Name (First, Middle, Last) i. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot ijury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) George Hatten Josephine Chapman 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Eligan (Daughter) 318 Tamarack Ct., Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2 Cremation 3 Removal from State Macedon remateur theseles permit. Page Department of Important: If any injury or 5 Other (Specify) Church Cemetery 5-15-2010 Suffolk, VA Donation 22. Name and Address of Facility Crocker Funeral Home, Inc. 900 E. Washington St., Suffolk, VA 23434 21. Sign neral Service License ature of Fu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Pulmonary Hypertension Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Physician: The law requires that the death certificate be executed Cause (Disease or linjury Congestive Heart Failure attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Colonic Pseudo Obstruction Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ Sick Sinus Syndrome Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Multiple Myeloma 24a. Was an autopsy performed? Yes 2 No After this certificate Prostate Cancer, Dementia 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗓 No 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural work? 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0062165 May 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Teshome Tegene, MD

31. Date filed (Month, Day, Year)

3001 Hospital Dr., Cheverly, MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ DRIS Month HANKE 11:52 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death
Baltimore 5815 Stevens Rd. White Marsh 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2**X**XF Months Days Hours Min (Month, Director 218-32-7960 76 Maryland June Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits White Marsh Baltimore 1 Tes 2XXNo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5815 Stevens Rd. 21162 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2XX Married 1 Yes XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 yrs. College (1-4 or 5+) Restaurant Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Pugh Hazel McGowan item 27 is marke other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles P. Hanke (Husband) 5815 Stevens Rd. White Marsh, Md. 21162 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. | 5~13~2010 Baltimore, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. Home assa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death MISSAS E Physician/ IUEL. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of, cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and dbe detached for use as the burial-tranthat initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autopsy performed? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 PM0 မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 888852 30. Name and address of Serson who completed cause of death (Item 23a) (Type, Print)

Konussul C. Sinumb 2835 Smin N

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20. 1 Decedent's Na ne (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) OV 16\_1930 1 X M 2 □ F Days Min. 79 212-26-7920 Director Nov VA Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified MD Carroll Woodbine 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5712 Woodbine Road 21797 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1947: Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 1950 3 XWidowed 4 Divorced Completed Specify: white Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) equestrian horse trainer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Estie Hobbs Mary Depew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9409 Old Marlboro Pike, Upper Marlboro, MD 20772 Lorraine Cox (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Department of P Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗖 Removal from State All County Cremation 5-12-10 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Paral Marght 9 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death Month Year Yes 2 No the detached g Unknown 9 Unknown signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b Were autopsy findings available prior to completion of cause of 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? Yes 2 No death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Spec 27. Manner eath 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident M 1 \sum Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print 5 State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2010 Physician/ Month Lawrence Walter Hyre Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6907 Wick Lane Montgomery <u>Derwood</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 1) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F West Virginia Director 60 212-54-2641 Nov Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Director or 28a-f sh notified a 1 🗆 Yes 2 屎 No Maryland Montgomery Derwood 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 72 hours after death with 20855 United States 6907 Wick Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Black, White, etc. Armed Forces' Completed by 1 ☐ Never Married 2 🔀 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced White Year or Dates. 1970-73 and Mental Hygiene.
is marked other than "natulgarmatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Software Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Jacqueline Lawrence Hyre Lenore 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Kathy Hyre/wife 6907 Wick Lane Derwood, Maryland 20855 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Ö 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State injury o 4 Donation 5 Other (Specify) Final Journey Crematory 5/14/2010| Woodbine, Maryland 21. Signal of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Thomas stinai M00957 Beverly L. Heckrotte. P.A. Clarksville. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Malignant 6 liona disease or condition resulting in death) Medical Due t as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Seizures 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2. 1 Inpatient 2 ER/Outpatient 3 DOA ည After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aff
bleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 13,2010 D0064099

Registrar

State

JOHNS HOPKINS HOSPITAL ISSO ORLEANS STREET IMIG BALTIMORE, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

BLAKELEY,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G903, 5/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:50 AM ones 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rmor Me ymound more 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Funeral 1 □ M 2 🔀 F Days Min. (Month, Day, 1) Year, 80 Months Hours Country) 578-46-723 Director 929 Georgia June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director D.C. N/A Yes 2 No Washington 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 1639 L. Funeral st. 20002 USA death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify Black 1 Yes 2 No Specify: Completed 3 √ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Hotel 12th N/A Be injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Williford ပ Eula Mae Nixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8331 Merrymount Dr. Windsor Mill, MD Paulette Hopkins/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State rinal Journey 1 Burial 2 X Cremation 3 Removal from State ematory or other place Cre:5/12/10 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charisse N. Woods F/S .,MD 21223 21. Signature of Funeral Service Licensee mark 2700 Edmondson Ave. Balto., MD Momentee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) ed by the detached 9 Unknown g Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 2 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Daughter's examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes · ≥ ☐ No ည 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title f certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOOD 32. Registrar' State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:50 P.M Frances Ruth Jones 2010 May 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard E1kridge 6636 Washington Blvd. Lot 101 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 1 🗆 M 2 🔀 F (Month, Day, Year) 2/04/1938 Country) Marvland Months Hours 71 216 36 0763 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No E1kridge Howard Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 21075 6636 Washington Blvd. Lot 101 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Staniewski Alexandria Michalski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

6636 Washington Blvd. Lot 101 Elkridge, MD. 21075

22. Name and Address of Facility Gonce Funeral Service, P.A.

Date

05/17/2010

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

GLEN BURNIE,

Baltimore, Maryland

Physician/ Medical Examiner

Physician/

Medical

Examiner

**Funeral** 

**Director** 

iral", or items 23a or 28a-f show Examiner must be notified at

"natural",

permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other tany injury or other traumatic event, the any injury or other traumatic event, the

Elmer Jones / Husband

21. Signature of Funeral Service Licensee

1 Burial 2 Cremation 3 Removal from State

4 □ Donation 5 🕱 Other (Specify) Entombment

20a. Method of Disposition

only one)

CARLOS

31. Date filed (Month, Day, Year)

the Medical

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans page 2 should has within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

1	January 3 mg	emerouski	4001	Ritchie High	way Baltin	nore, Man	yland 21225			
	23a. Part 1. Enter the disease, or complishock, or heart failure. Est only one immediate Cause (Final disease or condition						Approximate Interval Between Onset and Death G MONTHS			
	resulting in death)	Due to (or as a consequence of):					,			
	Sequentially list conditions, if any, leading to firm edictions. Enter Underlying Cause, Enter Underlying Cause (Disease or linjury that initiated events	Due to lor as a conservence of the conservence of t								
dical Ex	resulting in death) Last	Due to (or as a consequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to										
on indicate					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of			
	25. Was case referred to medical examiner?			26. Place of Death (Chec	ck only one)					
2	1 ☐ Yes 2 ☑ No	lospital: 1  Inpatient 2 ER/Outpa	atient 3 🗆 🗆	OOA Other: 4 Nursing H	lome 5 Residence	6 Other (Spec	cify)			
Lare.	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tim inju	28d. Describe how inj	ury occurred						
1 00 1	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
5	29a. Certifier 1 Certifying Physic	cian: To the best of my knowledge, dea	ath occured a	t the time, date and place, a	and due to the cause(s)	and manner as sta	ated. cause(s) and manner stated.			

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

S. CRAIN HWY.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (CARLOS D. ZIGEL, M. D. SUITE 106 1406

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 - 15123 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day William Joseph Kelnhofer May 2010 CM-3:45a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sykesville Fairhaven Carroll Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F 79 394-26-7096 Director Nov 24 1930 Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinar must be notified at MD Carroll Sykesville Director 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue Apt. 0407 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No Korea If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 <sub>Specify:</sub> white 1 □Yes 2 🛣 No Specify: ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Kelnhofer Mary A. Vetter မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave. Apt. 0407, Sykesville, MD 21784 Mrs. Ursula Kelnhofer (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 5-12-10 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Parge Haight a P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heimers disease or condition resulting in death) ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): vsician end e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 o 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2. 29b. Signature an title q rtifie

Registrar DHMH 17 Rev 1/2001

State

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

illiam

31. Date filed (Month. Day.

D34849

berty Rd & Idersburg MD 21784

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Marylar			Health and	Mental Hy	giene			
			1 - State Registrar			Cer	tificate of	Death		Reg. No.	2010	1 1 1 1	21
	Physici	an	Decedent's Name (First, Middle   )	11	20.0				2. Date of De Month	eath Day	Year	3. Time of De	'
	/Medic		4a. Facility Name (If not institution	Kouye			41. Oh. T.	Lasation of Das	may	8	2010	10,33	/ <sup>S</sup> M
	Examir	ier	Howard County			,	Columb	or Location of Dea	ui		ounty of Death .oward		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs		rth	9. Birth	place (State or F	oreign
	Director		577-62-7918	1 □ M 2 🖾 F	64	Yrs.	Months Days	Hours Min	Feb 24			<sub>intry)</sub> hington,	DC
	put 🔌		Usual Residence of Decedent  10a. State 10b. County		100 0	ity, Town or Loc	ation					10d. Inside City L	Limita
	f sho	ō		ard		Ellicot						1 ☐ Yes 2	
	the N	Director	10e. Street and Number				10f. Zip Code			10a. Citize	n of What Cou		
	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be reciffied at	Ö	13523 Triadel	phia Road	1		21042			USA		,	
	death	Funeral	11. Marital Status	12. Was Dec	edent Ever in U		Vas Decedent of I	Hispanic Origin? (	Specify Yes or No	o- 14	. Race - Amer		
92	after or ite		1 ☐ Never Married 2 🔀 Marr		2 <b>X</b> No	1	Yes, specify Cub	an, Mexican, Puei	to Hican, etc.)		Black, White, pecify: wh:		
Ö	ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I			111						
5	n 72 "nat	Set	15. Deceden (Specify only highe	t's Education st grade completed,	)	(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of wo	orking	16b. Kind	of Business/Ir	ndustry unk	
212	filed within 72 Hygiene. other than "na ent, Ire Medic	Completed	Elementary/Secondary (0-12) unk	College (	(1-4or 5+) <b>k</b>								
Maryland 21215-0036	other other /ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle	, Maiden Sι	ırname)		
<u> </u>	2 should be f h and Mental I ' Is marked of raumatic eve	To E	Claude Leonia	n Manuel				Thelma	Dee Wit	t Nix			
a	2 sho and Is ma		19a. Informant's Name/Relations			19b. Mailin	g Address (Street	and Number or F	lural Route Numb	er, City or T	own, State, Zi	p Code)	
	es 1 and 2 should be of Health and Mental litem 27 Is marked crother traumatic ever		Thomas Kouyea	s/spouse				phia Roa					
Baltimore,	ges 1 nt of H iffite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from		Place of Dispos cemetery, crem	sition (Name of natory or other pla	ce)	Date	20c. Loca	ition - City or T	own, State	
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			<sup>3</sup> 23a. Part . Enter the disease, or	complications that	caused the deal	th. Do not ente	Baltimor or the mode of dyi	e, Maryl ng, such as cardia	and 2120 ic or respiratory a	rrest,		Approximate	
-	Physician	i ii	shock, or heart failure. List Immediate Lause (Final			111	A. 1	NFAL	MAIT			Interval Betwee Onset and Dea	en eth
	/Medical		disease or condition resulting in death)		(or as a consec		1	14/ 1/1	( ) 102-				
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X Q Q	w requires that the death certifichen signed by the attending ishould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnation		Ectopic pregnanc			23	d. Date of deliv	ery	ļ
D	ed for	sicie	in the past 12 months? 1 ☐ Yes 2 No		gnant at time of		Other (specify)	,y			Month	Day Yea	ır
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	been should	Completed											
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	an: T tificat or, pa		25. Was case referred to medical			-		00 Pl ( P-	1 ☐ Yes	2 XNo	1 ☐ Yes	2×100	
=	Physician: rthis certific ral director,	To Be	examiner? 1∐Yes 2∭No	Hospital:	Inpatient 2	ER/Outpatient	3 DOA Oth	or.	ath (Check only of Home 5 ☐ Resi		Other (Space	i6.1	
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0	endir sath. or: Al	atic	2 ☐ Accident investig	ation	ran, Day, roan,	,,		Yes 2 □ No					
DIVISION	or Att frer de virect in by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place build	e of Injury - At he ling, etc. <i>(Speci</i>	ome, farm, stre fy)	et, factory, office		28f. Location (	Street and I wn, State)	Number or Rur	al Route Number	ç,
3	pital o		29a. Certifier Certifyin	g Physician: To th	a hast of my line					4.)			
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical one)	Examiner: On the l	e best of my kind pasis of examina iner stated.	ation and/or inv	estigation, in my	opinion, death occ	e, and due to the urred at the time,	date and p	nd manner as lace, and due i	to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certified		•		29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)	
			W. Arm	1			100	53051		MA	y 10	201	0
			30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type, F							
			W. Althea; 575 31. Date filed (Month, Day, Year)	5 Cedar	Lane; Co	olumbia	, Maryla	nd 21044					
	Stat Registra		If A Y 1	4 2010	logotiai s Signa	A A	ball						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ma V 10:50 P George M. Lubin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Ellicot City Morningside House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Hours 10718719<del>2</del>5 Baitimore, MD Director 213-20-7656 84 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Elkridge 1 Yes 2 X No Marvland Howard 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21075 U.S.A. 6511 Fallston Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, rmed Fo Black, White, etc þ 1 Never Married 2 X Married 2 🗌 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify Specify: White WWII 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore Gas&Electric Underground Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Matthew Lubin Tcherankonvich Anastasia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6511 Fallston Road, Elkridge MD 21075 Phyllis Lubin-Tyler/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specify)emtombment|Dulaney Valley Maus. |May 14,2010| Timonium, Maryland Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility 22. Name and Address of Facility Towson, Ruck Towson Funeral Home, MD 21204 , Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Oronary Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No sate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 Yes 2 No Yes 2 No Be the funeral director, 25. Was case referred to medical 26. Place of Dea (Check only one) Hospital Other: 1 ☐ Yes 2 📈 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man/ner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🚺 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No safter death 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year)

Registrar

DHMH 17 Rev 7/2009

State

Ellicot

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	·03421 rlene Laurear			ment c	I <b>nk. Ens</b> of Health of Death	and I	All Copies Mental Hyg	giene	2.0	110	15126
	Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	Todio o	- Dodin			Date of Death	Day Y	ear	3. Time of Death 1630 hrs
IVI	edical Exami	ner	Marlene Laureano-Cancel  4a. Facility Name (if not institution, give street and number)  2936 Greenmount Avenue		4b. City, Tov Baltimo		cation of Death	May 3, 201		y of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under			8. Date of Birtl	(MM/DD/YY	9. Birti	nplace (State or Foreign
	Director		134-58-0711 1 M 2XF	39 Yr		Days	Hours Min.	03/09	/1971		NY
	ž.		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Loca	ation						10d. Inside City Limits
	daryland 28a-f show an	Į.	Maryland N/A				altimore		g. Citizen of \	Mhat Coun	1 X Yes 2 No
	h the Mary 23a or 28a- totified at	Director	10e. Street and Number		10f. Zip Co		21218	1"	g. Citizen or i	USA	u y :
	rith the 23a o		2936 Greenmount Avenue  11. Marital Status 12. Was Decedent Ever in U.S.	13. W	as Decedent	of Hispar	nic Origin? ( Spe	cify Yes or No-		ce - Americ	can Indian, Black,
0	more, MD 21215-0036 Pages 1 and 2 should be filled within 72 hours after death with the Maryland near of Health and Montal Hygier with 72 hours after death with the Maryland in the filten 27 is marked other than "natural", or items 23a or 28a-faho no other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year				lexican, Puerto R			nite, etc.	White
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	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	BeC	17. Father's Name (First, Middle, Last)  Tomas Laureano			l i	Maria	E.	Gonza		
	D 21215-005 should be filed within and Mental Hygiene. 7 is marked other that	70 E	19a. Informant's Name/Relationship (Type, Print )				nd Number or Ru				
	MD and 2 sho alth and 2 is 27 is wumati	·	Maria E. Gonzalez						. 3J, B 20c. Locatio		NY 10460
	Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumat		1 Burial 2 X Cremation 3 Removal from State	matory or o	osition (Name other place)		Мау				
	Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	Ш	4 Donation 5 Other Specify:  21. Signature of Funeral Service Ligensee	-	Crema Name and A		F 100	010			New Jersey
	Bal permi Depar Impo injur	Ų.	21. Signature of Purieral Service Liverisee	1			Stain Ro	_			ome, P.A.
	Physician		23a. Part I. Ent. the disease, or complications that course the death. Defailure. List only on cause on each line.	o not enter	the mode of o	dying, su	ch as cardiac or r	espiratory arre	st, shock, or	neart	Approximate Interval Between Onset and
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		nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
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	Box 68760, e death certificate be executed the attending physician and ted for use as the burial - transit	lical	Xunpended AMENDED 23a,27,28a-f,p	or FM	904	6/28	/10 TT				
	760, cate be physic he bur	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregna	ncy						of delivery	
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	Vital Rec ysician: The l his certificate l director, page		25. Was case referred to medical		26	Place of	Death (Check or		2 No	1 Ye	s 2 No
	/ital siclan is cert	o Be	evaminer?	R/Outpatie			her Nursing		Residence 6	Other	: Scene
	n of \ ling Phy After th	⊢	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	8b. Time of	f Injury 28			8d. Describe h	expos	urred	carbon
	ttendi death.	atio		d 4:4	l pm		2 24110	monoxid	e		
	Divis tal or A	Certification:	3 Suicide 6 Could not be determined (Specify) House	ie, farm, str	eet, factory, c	office build	ding, etc.	Baltimo	ree 2936 re, MI	Gree	ral Route Number, City mount Ave.
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Completely the runeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buria	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) 2 ✓ Medical Examiner: On the basis of examination and	, death occ /or investig	urred at the ti ation, in my o	me, date pinion, d	and place, and death occurred at	ue to the caus the time, date	e(s) and man and place, an	ner as state d due to th	ed. e cause(s)
,	To Wit	Me	and manner stated.  29b. Signature and title of certifier		29c. I	License r	number				nth, Day, Year)
			Land & Swithell, MD		(	O.C.M.	E.		May 4, 2	010	
ħ			30. Name and address of person who completed thuse of death (Item 2 Pamela E. Southall, MD Assistant Medical Exam		11 Penn 9	Street	Baltimore, M	D 21201			
U		tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature								
7	Regi		MAY 1 4 2010 A	1	/			_			
*	DHMH 17 Rev 1/	2001	penasa	ORIGH	Acare			Com			

For amend item 9 per ab g 904 6-3-16 partitions of Health and Mental Hygiene Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Month IAWSON LBERT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore orthwest HOSPITAL Randallstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | July 17, 1945 Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 1 ☑ M 2 ☐ F 212-42-5669 Director 64 Usual Residence of Decedent or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I firem 27 is anawled other than "natural", or items 23a or 28a-f sho important: If item 27 is anawled other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Baltimore Woodbridge 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1525 N. Rolling Road 21228 USA 11. Marital Status unk . Was Decedent Ever in U.S. Armed Forces? UNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Jewish Community Elementary/Seconday (0-12) College (1-4 or 5+) Center Printer Be 17. Father's Name (First, Middle, Last) - unl 18. Mother's Name (First, Middle, Maiden Surname) ank Albert Lawson Naomi Braxton 19a. Informant's Name/Relationship (Type, Print)
Herbert Lawson/ Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2214 Cloville Ave. Baltimore, Md. 21214

5401 Old Court Road; Randallstown, Maryland <del>Northwest</del> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) cemetery, crematory or other place) Final Journey 5-21-10 Woodbine, Md Cromartie F/ Name and Address of Facility Beverly D 21. Signatur of Euneral Service Licenses Rona d S 23. Name and Address of Facility Act a 2700 Edmondson Ave . Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sepsis Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☑ Yes 2 ☐ No Other: ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29c. License number D65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 5401 Old Court Road, Randalls Town, HD 21133 Abdallah Katrouri 31. Date filed (Month, Day, Year) 32. Registral's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milburn Month W 17:36 avid 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY of Maryland medical centre Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1270671955 1 X M 2 🗆 Months Days Hours Min. Director 54 Maryland 212-70-1082 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Ħ Director notified 1 Tes 2 No Fairfield Adams PΑ 10g. Citizen of What Country? 10f. Zip Code 9 10e. Street and Numbe Examiner must be 23a Funeral 26 Diane Trail 17320 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Black, White, etc. ō 1 Never Married 2 X Married by 2 X No Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates "natural" Completed 3 Divorced 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Frederick County Gov. <u> Inmate Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ . Page 1 and 2 should be Miriam K. LeMaster Chester F. Milburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17320 26 Diane Trail - Fairfield, Pennsylvania <u>Margaret M. Milburn</u> Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or oth 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Michael Luth Cem. 05/13/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee Levito 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final LUMONUBLASTIC .Physician/ acute disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Duá fu tár as a conscaucince on. Exami and -transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death the detached Linknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed be should be det Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a, Was an Hospital-or Attending Physician; The law page 2 s has death? within 24 hours after death.

To the Funeral Director, After this certificate is committed filled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🔲 Yes 2 No 1 MInpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injun work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State Registrar S. Grene

Baltimore,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

Back

Danelle (31. Date filed (Mopth, Day, Year)

May, 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Doris 1100 AM 2010 Marie Moore 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Itmore N/A If Under 5. Social Security Number 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 17 1 Birthplace (State or Foreign Country) **Funeral** Months Min. Days Hours 1 □ M 2 😡 F 215-18-2983 Sept. 88 1921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Glen Burnie Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 200 Fernglen Avenue 21061 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No \$ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker 12 Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Bertha Gilbert Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delbert T. Moore 200 Fernglen Avenue, Glen Burnie, MD 21061 Date 11 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 2010 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Part 1. Inter the dis self, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, it heart failure. List only one coluse in each line. Approximate Interval Between Onset,and Death 23a, Part 1 Immediate Cause (Final disease or condition resulting in death) day Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 2 10 Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗋 Yes ဥ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

requires that the death certificate be executed P.O. Box 68760,

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item az 7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. "A water Examine must be ruitlied.

Physician

Examiner

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attending physician

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completely filled in by the funeral director,

Medical

4 ☐ Homicide

29a. Certifie

/Medical

Maryland 21215-0036

Baltimoré,

Division of Vital Records, To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica

State Registrar

and manner stated. 29b. Signature and title of certific

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

> e of death (Item 23a) (Type, Print) grenve Baltimore MD 21229

30. Name and address of person who completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,13 tate of Mary Tants Abear ment of Mean and Mental Algoric JH For State Certificate of Death Reg. No! -2-0-1 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2°0°10 Cleveland McDougal 8:09 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 ፟ M 2 □ Days Hours Nov 22, 1922 Director 240-26-4091 87 North Carolina Usual Residence of Decedent 10b. County unk 10c. City. Town or Location 11nk 10d. Inside City Limits Director DC 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1221 M Street NW #107 20010 USA 12. Was Decedent Ever in U.S. Unit 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 11. Marital Status unk 14. Race - American Indian, Armed Forces?

Typy Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: black 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Handyman unk permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ Dallas McDougal Bella Docier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
35600 Charleydix CT, Apt 307 Richmond, VA207 Rechmond, VA207 Raryland, VA207 Raryland, VA-Olivia McDougal Thoms/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in State Signature of Funeral Service Licensee Ronald S. Wade Director <sup>22</sup>State Anatomy<sup>ny</sup>Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Par 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line.
Immediat vause (Final Onset and Death Physician/ a hypertensive cerebral vascular accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, day Leading 15 in moderates. Enter Underlying Cause (Disease or iinjury Dun to for as a nonsectioned of: physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ aorticstenosis Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has be irector, page 2 s 1 ☐ Yes 2 ☒ No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practionery to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number D 31528 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly, ND 2018 Dr. Margaret Akpah 3001 Hospital DR 31. Date filed (Month, Day, Year) 32. Regieras's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type 26 Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Peath 2. Date of Death Physician/ Month. 12, Nellie W. Nelson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 8. Date of Birth (Month, Day, Year) OCt. 31 1921 **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 F Hours Min. Country) 218-22-1084 88 Yrs Director MD Usual Residence of Decedent items 23a or 28a-f show ler must be notified at rector 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Maryland 1 Tes 2 X No Anne Arundel Pasadena 這 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8059 Long Hill Road 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give filed within 72 hours after 1 ☐ Yes 2 ☒ No Specify: "natural", 3 X Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Burgie В. Willett Edna D. Pickeral 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Derr (daughter) 7810 Clark Road, D40, Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of Cedatry, Heightly Cemetery 20c. Location - City or Town, State Burial 2 Gremation 3 Removal from State May Department of Important: If any injury or once, 4 Donation 5 Other (Specify) Baltimore, Maryland 2010 21. Signatur of Futieral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 211 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specifical Unknown) 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deals? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at stated. only one 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 2016

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 Daniel Norfleet 2010 7:46aM Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Balto N/A . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🖳 M 2 🗆 F Days Hours Month, Day, Year 62 Months 108-58-3576 **Director** 48 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f sho filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Spring Valley 1

Yes 2 □ No N.Y Rockland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10977 119 Bethune Blvd S 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 ☐ Married Black, White, etc. þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Black Completed 3 Widowed 4 Divorced Specify. I Hygiene. other than "natura rent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry na Give kind of work done during most of working na (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I once. 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Rita Fitz Leroy Norfleet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) D. Malling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) VA 1012~E.~Kensington~Circle~Fredericksburg , Gregory Norfleet-Brother 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount Date 20c. Location - City or Town, State 4-20-2010 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funers Service Licenses 22. Name and Address of Facility March East F/H  $\mathbf{F}$ North Avenue Balto MD. <del>21202</del> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition 10 and Medical resulting in death) Due to (or as a onsequence of) Examiner Sautentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Por in the past 12 months? Day Pregnant at time of death
Unknown been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate Yes or Attending Physician: 25. Was cas eferred to medical Be 26. Place of Death (Check only one) examin ? 2 No Other: မ 1 Inpatient 2 5 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 5 Pending within 24 hours after death. To the Funeral Director: A 2 🗌 No Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene,-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** FRANK J. NEMIC, SR. 10, MAY 2010 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9602 AMBERLEIGH LANE APT.PERRY HALL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Min. 1∭ M 2□ F Months Days Hours 215-24-9785 80 Director 10/23/1929 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f st adical Examiner must be notified 1 ☐ Yes 2 📉 No Director BALTIMORE PERRY HALL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9602 AMBERLEIGH LANE APT. 21128 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 □Yes 2 🔯 No Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: ≥ Specify: 3 Widowed 4 Divorced WHITE Completed er than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT STATE OF MARYLAND 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 77 is marked traumatic e FRANK L. NEMIC ANNA DOLIVKA မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOYCE NEMIC/WIFE 9602 AMBERLEIGH LANE APT. PERRY HALL, MD 21128 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/2010 MORELAND MEM. PARK HILLENDALE, MD 21. Signature of Funeral Service Licensee MO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comunications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Immediate Cause (Final Physician day disease or condition resulting in death) /Medical Due to Examiner ousease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner (or as a consequence of): The law requires that the death certificate be executed ensi attending physician and for use as the burial-tran resulting in death) Last ( r as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an paga 2 s autopsy 1 □Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0014782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, Osler Dr. #305 -D 1565 31. Date filed (Month, Registrar's

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death oital Funeral 8. date of Birth 9. Birthplace (State or Foreign 1 M 2 KF Months Davs Hours Min. **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White, etc 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 Yes 2 Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education ecify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be ٥ 19b. Mailing Address (Street and Number or Rural Route Nur Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Temation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee No 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Physician MYOCARPIAL Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ABETE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the bunal-transit HORB(D UBES 17 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) 1 Yes 2 🗆 No ဂ္ Other: 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erfis Pate	State of Maryland / Department of I		ygiene Z U Reg. No.	10 1513:
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last)  Perfis Pate		2. Date of Death  Month Day Year  May 10, 2010	3. Time of Death 1230 hrs
•	4a. Facility Name (if not institution, give street and number)  4b	City, Town, or Location of Death		Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-34-6113 1 M 2 F 75 Yrs.	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	<b>-</b>	9. Birthplace (State or Foreign Country) MD
1215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene.  aarked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.  De Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2x No 1 Yes 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+)		Rican, etc.) White, of Specify:  work done 16b. Kind of Busin	American Indian, Black, etc. Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	Perfis Pate, Sr  19a. Informant's Name/Relationship (Type, Print)  Arlene Perkins-Sister  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  1 State of Disposition Crematory or othe Mt Zion	Mamie Address (Street and Number or F corn Circle Ar on (Name of cemetery, ir place) Cemetery 5-1	Grist, Middle, Maiden Surname)  J. Austin Rural Route Number, City or Town, Date 204 Towson, Date 20c Location - C L4-2010 LANSDO March East F/F	, MD 21286 Lity or Town, State
Physician 'Medical .aminer	23a. Párt i. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  a. Atherosclerotic Cardiovascular Disease or condition resulting in death)  b	mode of dying, such as cardiac o	Avenue Balto or respiratory arrest, shock, or heart	
P.O. Box 68760, es that the death certificate be executing gred by the attending physician and be detached for use as the burial - training by Physician/Medical	JUNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  AMENDED  23c. If yes, outcome of pregnancy 1 Live birth 2 Feta 4 Pregnant at time of death 5 Other 9 Unknown	al death 3 Ectopic pregna er (Specify) derlying cause given in Part I.	23d, Date of do Month  23e. Did tobacco use contributorial and the second secon	Day Year ute to the cause of death?
tal Records, Itian: The law requires certificate has been sig ector, page 2 should be Be Completed			autopsy pri performed? de 1 Yes 2 ✓ No 1	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Division of Vii bours after death. Increal Director: After this y filled in by the funeral dire Certification: To	1 Ves 2 No Inpatient 2 ER/Outpatient  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  28e. Place of Injury - At home, farm, street (Specify)	ury 28c. Injury at Work?  1 Yes 2 No , factory, office building, etc.	28d. Describe how injury occurred 28f. Location (Street and Number or Town, State)	or Rural Route Number, City
To the H. within 24 To the F. Completel completel	Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier  When the basis of examination and/or investigation and manner stated.  30. Name and address of person who completed cause of death (Item 23a)	29c. License number O.C.M.E.		(Month, Day, Year)
State	at the state of th	Street, Baltimore, MD 212	201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Poland Gloria Mae Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Loch Raven Center Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1/30/1924 Hours 1 □ M 2 😾 F South Carolina Director 86 215-16-0600 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 Yes 2 XNo Baltimore Essex Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? **Completed by Funeral** 21221 S. Brett Court Apt 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bottle Manufacturer Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **Johns** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Ledwell (Daughter) Kittendale Circle Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Eastern Avenue Home Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or andition resulting in death)

a. Due to (or as a consequence of): interval Between Onset and Death Ph\_sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No Hospital or Attending Physician: The law certificate has 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 2 📈 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident (Month, Day, injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

17

30. Name and

31. Date file

Sicrem

(Item 23a) (Type, Print)

32. Registrar's Signature

address of person who completed cause of death

75U

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Herbert Rice 6:46 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Baltimore Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 228-38-393 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD NOSOR 10e. Street and Number 10g. Citizen of What Country? Funeral 10 HANNA 2124 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No 6/19/56 If Yes, Give Year or Dates. 6/3/58 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Post OFFICE SupERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT D. CANNAdY THEIMA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby L. Ric BALTIMORE, MARYLAND 21244 WIFE HANNA COURT, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19/2010 Owings Mills, MARYIAND Signature of Funeral Servi & icensee 22. Name and Address of Facility The DERRICK C. JUNES FIH, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Bladder Cancer Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Enter Linearlying To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown /24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 ☐ No patrent hospice 4 Nursing Home 5 Residence 6 Other Spe 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accider
3 Suicide Accident Investigation filled in by the 24 hours after deat Funeral Director: 6 
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hours to the Fune completed file 29b. Signature and title of certifing 29d. Date signed (Month, Day, Year) MSRajapahse M.D D0057465 5/12/10

Registrar

DHMH 17 Rev 7/2009

2835 Smith AV.

5.235 , Baltimore, MD. 21209

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 9:50 A M 1<sup>Day</sup> 2010 Rickerds Doris May 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) May 19, Year 929 Days Months Hours Baltimore, MD 1 🗆 M 2 💢 F 217-24-4297 80 Usual Residence of Decedent 10d. Inside City Limits 10b, County 10c. City, Town or Location 10a, State 1 Yes 2 KNo Towson Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21286 549 Valley View Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Μ. Bekoski Theresa Andrew Ε. Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Brookridge Court, Timonium, MD 21093 19a. Informant's Name/Relationship (Type, Print) Earl C. Rickerds/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland May 17,2010 Dulaney Valley Mem. 22. Name and Address of Facility Towson, MD Ruck Towson Funeral Home, 121204 Inc. 1050 21. Signature of Funeral Service Licenses York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer Varian disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of)

Physician/ Medical **Examiner** 

Physician/

Medical

**Examiner** 

**Funeral** 

Director

ms 23a or 28a-f shov must be notified at

th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu

Health tem 27

permit. Page 1 a
Department of H
Important: If ite
any injury or ot

Directo

Completed by

Be

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be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and To the Hospital or Attending Physician; The taw requires with 124 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Certificate: To Be Completed by Physician/Medical Examiner

dical Examin	if any, leading to infillediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence)	ence of):			
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No 9 \( \end{ye} \) Unknown	23c. If yes, outcome of pregnal 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Lectopic			23d. Date of delivery Month Day Year
	Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying	g cause given in Part I.		o use contribute to the cause of death?  2 XNo 3 Probably 4 Unknown
Completed					24a. Was an autopsy performed 1 Yes 2	
	25. Was case referred to medical			26. Place of Death (Che	ck only one)	
To Be		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆	DOA Other: 4 Nursing I	lome 5 Residence	6 Other (Specify) HOSPICE
	27. Manner of Death  Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factor)	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical Certificate:	(a) I O Bit a dia al Paramaia	sician: To the best of my know ner: On the basis of examination se Practioner: To the best of m	n and/or investigation i	n my opinion, death occurred	at the time, date and pla ace, and due to the caus	se(s) and manner as stated.
				- 44	004	Data signed (Month Day Voor)

25

N. CHARLES ST.

29d. Date signed (Month, Day, Year)

Towson.

State Registrar 29b. Signature

McLISSIA

and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WOU

32. Registra's Signature

6101

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 5 Year 715 A RCel 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ROSS MONtgomery ilver 4 Hrs. 8. Date of Birth
Min. (Month, Day, Year)

06 21 - 193 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) VA. 1 M 2 M Months Hours Min. Director Usual Residence of Decedent 23a or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Fyes 2 No wen 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 090 8502 Dr ONA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BIACK If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Tech. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam ဂ္ Ruth 3 ا دن د Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOMYA 9348 POBOX HAMPTON, VA. 23670 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Dedrial 2 Cremation 3 Removal from State 05-17-10 4 Donation 5 Other (Specify) BRENTWOOD 21. Sigpature of Funeral Service Licensee 22. Name and Address of Facility The House of well imms William Georgia WAShi Dic Zooli Ave N.W. MO 1182 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Multiple Drug Resistant Sepsis Sequentially list conditions, Examine If any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death Month Day Year been signed by the a should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Multiple Myeloma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performe death? Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 1 Yes 2 **K**No 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signaty and title 5/6/2610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
K G UP FON 9861 Geometri 10 Georgin

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

1 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 06 Harry 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mary center and Birthplace (State or Foreign Country) 5. Social Security Numbel Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours 11☑ M 2□ F 27 1948 MD 61 Dec. 212-56-4143 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Maryland Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 10022 Hayes Landing Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑ No Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Robert Unknown Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8082 Castle Rock Court, Pasadena, MD 21122 Lisa Winslow (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5/11/10 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens e Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseaschock, or heart failure List only one cause Immediate Cause (Final disease or condition resulting in death) hepatorera Syndrome Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last alcoholism Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Hygiene. other than "natural",

permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

Baltimore, Maryland 21215-0036

signed by the atte has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

MARCHOWEJOK US IS DEF ME

Vital

ot

Division

Physician/Medical

Completed

Be

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

i illy

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

Physician

29c. License number P24444

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONG 22 South Greene Street ALICE 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

MAY 1 4 2010

Baltimere. Mb 21201 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Ricany 2:45A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1411 Bowles Terr. Forest Hill Harford 5. Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Months Days Hours (Month, Day, October Country) New Jersey Director 144-46-2564 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2X No Harford Forest Hill Md. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1411 Bowles Terrace 21050 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, et-Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2 No res, Give Year or Dates. 1972–1978 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nday (0-12) College (1-4 or 5+) Yard Manager Lumber Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George Ricany Grace DeAngelis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ricany Spouse 1411 Bowles Terrace Forest Hill, Md. 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 5-17-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd. Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset and Death Immediate Cause (Final Glioblastoma Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has the irector, page 2 s autopsy perform 2 X No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Certificate: To Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ithin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu 2 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗌 only one 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

d address of person who completed cause of eath (Item 23a) (Type, Print) TAISHU BLAKELEY,

STREET

D0064099

RBITIM-16

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	tate of Maryland / D		ent of Healti ate of Dea			giene Beg. No.	0 1	5142
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	20015	RAH	E , S1	R	2. Date of De Month	Day	Vear	ime of Death
	Exami		4a. Facility Name (If not institution, give street	et and number)		ty, Town, or Location	ion of Death	15	4c. County	of Death	
	<b></b>		TRANSITIONS +  5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Uno	, ,	der 24 Hrs.	8. Date of Bir		9. Birthplace (	
	Funeral Director		215 24 2404 1XM	005	Yrs. Month			JAN 4	1928	MARY	_
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Towr	or Location					10d, Ins	side City Limits
	the Marylan 28a-f ehow	tor	MO CARROLL	- SYKE	ESUIL	E					Yes 2 □ No
	ith the M or 28a-f	Director	10e. Street and Number			Zip Code	. 1		10g. Citizen of V		
	s 23a			Was Decedent Ever in U.S.	10 M D-	2178	<u> </u>	-#-W N-	US	- American Ind	
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or itams 23a or 28a-f ehow uther, the Medisel Everificat must be notified at	by Funeral	1 Never Married 2 Married	Armed Forces? I □ Yes 254 No f Yes, Give		pedent of Hispanic pecify Cuban, Mexi No Spec		Rican, etc.)	Blac	k, White, etc.	
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215	ithin 7 ne. nan "n	Completed	(Specify only highest grade co	College (1-4or 5+)	life. DO NOT	,	nost of workir	ng .	SHRE		
d 21	be filed withintal Hygiene. Ind other than	Col	17. Father's Name (First, Middle, Last)	0 1	MACH	LINIST	other's Name	(First Middle	Maiden Sumam	R CO.	
lan	e d fa	To Be	UNKNOWN					nown		-,	
Maryland 2121	s 1 and 2 should be filed within f Health and Mental Hygiene. Itam 27 is markad other than othar traumatic evant, Ira M	-	19a. Informant's Name/Relationship (Type,			ss (Street and Nur	mber or Rura	Route Numb	er, City or Town,		
	1 and Health am 27 thar tr		BARBARA RAHE  20a. Method of Disposition	20b. Place of	Disposition /	AKANA lame of	MIL	L RO	SYKES!	VILLE !	710
nor	Pages ent of nt: If it y or o		1 Burial 2 Cremation 3 Remo	cameter	v. crematory o	Caem.	1 .	/			
Baltimore,	permit. Pages 1 and Department of Health Important: if itam 27 any injury or other tr once.		21. Signature of Funeral Service Licensee	2040-1-	22. Name	and Address of Fa	acility \ N &	Punku	WHIP	novie.	(0
8	8828		Jet N. Sum	<u> </u>		S SYKE.				surc-n	0 21784
	Physician /Medical		23a. Plint. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)		MER	S DEN			rrest,	Interv	eximate ral Between t and Death
8760,	eate be executed this sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of							
O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transl	Physician/Med	in the past 12 months?	f yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	3 □Ectopic 5 □ Other (				23d. Date Mor	e of delivery nth Day	Year
ds, P	juires that n signed b ild be deta	by	Part II. Dther significant conditions contribu	iting to death but not resulting in	the underlying	cause given in Pa	art I.		obacco use contr Yes 2□No	ibute to the caus	se of death?
Vital Records,	e law has b je 2 sl	ompleted							an 24b. V	Vere autopsy fin rior to completic leath?	dings available on of cause of
/ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?			26. Pla	ace of Death	1 ☐ Yes (Check only o		163 2010	
of \	Phys this al di	<u>۲</u>	1 ☐ Yes 2 ☐ No Hospi 27. Manney of Death 21	1 Inpatient 2 EH/Out					dence 6 Othe		
lon	fter ne	tion	1 Natural 5 Pending 2 Accident investigation	Ba. Date of Injury (Month, Day Year) 28b. Ti	jury M	28c. Injury at Work? 1 ☐ Yes 2	1	od. Describe	now injury occurr	₽d	
Division of	after dea Diractor	Certification:	2 Could not be	Be. Place of Injury · At home, far building, etc. (Specify)	m, street, facto	ory, office	2	8f. Location ( City or To	Street and Number wn, State)	er or Rural Route	Number,
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	edical C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and and manner stated.	death occurre Vor investigation	d at the time, date on, in my opinion, o	and place, a death occurre	nd due to the d at the time,	cause(s) and ma date and place, a	nner as stated. and due to the ca	iuse(s)
	To th within To th comp	Me	29b. Signature and title of central	1	2	9c. License numbe	өг		29d. Date signed	(Month, Day, Y	ear)
			1/2/	/	0	DS77	22		MAY	13 20	10
			30. Name and address of person who completed with the complete states of the complete state	RPSON M.D. 1	Type, Print) 838 G	REENE T	TREE	LUAD #	300 PILL	ESVILLE ,	40 21208
	Sta Registr	- 3	31. Date filed (Month, Day, Year)  MAY 1 4 2010	32/Registrar's Signature	barke	,			7		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 0 ear Physician/ May 13, GEORGE HENRY STEELE 8:34PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Towson Baltimore Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign DECenth 2014, 1937 XX M 2 D F Months Hours MaryTand Director 218-34-0889 72 Usual Residence of Decedent other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2XXNo Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8410 Charles Valley Court 21204 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 1 1 X Never Married 2 Married Black, White, etc. ò Maryland 21215-0036 1 ☐ Yes 2XXNo If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Professor College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F George Steele Elizabeth Brown Hewes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Shipley Road Linthicum Maryland 21090 Linda Lee Betz Cousin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
GreenMount Crematory 20c. Location - City or Town, State Date May 15,2010Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Se 22. Name and Address of Faffitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications Approximate Interval Between Immediate Cause (Final Onset and Death rena Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 600 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine I or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the at d be detached fo g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending s after death. Accident Suicide Investigation 1 Yes 2 No 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar

Creok

N. Charle

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland /			lental Hygien	Э	
			State Registrar		Certificate of L	Death	Reg. N	0. ) )   (	715144.
	Physicia		1. Decedent's Name (First, Middle, Last)	Naurice	Sheph	erd	2. Date of Death  Month  D	13 2010	3. Time of Death 3:15 AM
	Medic Examin		4a. Facility Name (if not institution, give s	1 1/000	4b. City, Town, or	Location of Death	W 1570	c. County of Death	A
	Funeral		5. Social Security Number 6. Sex	VV	ofrthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Year)	9. Birth Cou	nplace (State or Foreign ntry) NEW VIVIL
	Director		Usual Residence of Decedent  10a. State  10b. County	10c City To	own or Location		1000		10d. Inside City Limits
o de la constantina della cons	Maryland 18a-fsh Viffied a	recto	MD ISSUED NO. COUNTY N	IA COM, IS	Baltin	100			1 Nes 2 □ No
4	23a or 2	Funeral Director	10e. Street and Number 1802 Euta	w Place	10f. Zip Code	2121	7 10g. C	Citizen of What Cou	intry?
36	alle deall	by		12. Was Decedent Ever in U.S. Armed Forces? 1 Fes 2 No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	p, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
Maryland 21215-0036	alled within 7.2 flours aren death with the waayand tall Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Midical Examiner must be notified at.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	ucation 16	6a. Decedent's Usual Occup (Give kind of work done of life, DO NOT use retired)	ation during most of working	ig 16b.	Kind of Business In	ndustry LMD
and 2	5 F 7 O	To Be (	17. Father's Name (First, Middle, Last)	oherd.	0110010/100	18. Mother's Name	e (First, Middle, Maider	n Surname)	S
	th and M th and M 27 is mai tranmat	3	19a. Informant's Name/Relationship (Type)	oe, Print)	19b. Mailing Address (Street )	and Number or Rura	Route Nymber, City of AUC	or Town, State, Zip Bulto-	Code) 21257
<u> </u>	rage I and and and an of the self and the self it is an it. If item 2 any or other		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5  Other (Specify	20b. Place Removal from State	e of Disposition (Name of etery, crematory or other place	4 1 = /	Date / 20c.	Location - City or Batton	Town, State
Baltıı	permit. Page Department Important: I any injury o once.	9	21. Signature of meral ervice Lic no	x hour Si	22. Name and Addre	1	well F	AU B	Ito the
			23a. Fart 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final						Approximate Interval Between Onset and Death
	nysician Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	*	ACCI MEN	41		
	sit.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ms ion ce of):			-	
_	physician and the burial-transit	al Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
760	physics the t	edical		di					
Division of Vital Records, P.O. Box 68	o the Hospital or Attending Priysician: The law requires that the beart Certuro, which 24 hours affer death.  To the Funeral Director, After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live Birth 2  Fetal de 4  Pregnant at time of deat g  Unknown	eath 3 🔲 Ectopic pregnan	су		23d. Date of delivery Month Day Year	
s, P.O.	signed by	þ	Part II. Other significant conditions co Diachetes Swallowing	ntributing to death but not resultin	ng in the underlying cause gi	ven in Part I.			the cause of death?
cords	iaw requii has been e 2 should	Completed	Swallowing	Disorde			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
٠ س	icate r, pag		25. Was case referred to medical		26 D	lace of Death (Check	1 Yes 2	No 1  Yes	2 No
/ita	sicial certifi irecto	o Be	evaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER	Inth		ome 5 Residence	6 ☐ Other (Spec	ifv)
o ¹ oŧ	grnys erthis neraldi	te: To	27. Manner of Death		b. Time of 28c. Injury work	y at	28d. Describe how inj		
ion	tendin death. tor; Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		M 1	Yes 2 □ No	28f. Location (Street a	and Number or Ru	ral Route Number,
Divis	urs after ral Direc		4 L Homicide determined	building, etc. (Specify)		data and place as	City or Town, Sta	ite)	
	e Hosp 24 ho e Fune bleted fi	Medical	(Chock 2 Medical Evami	ician: To the best of my knowledg ner: On the basis of examination an e <b>Practioner:</b> To the best of my kn	nd/or investigation, in my opini	on, death occurred a	t the time, date and pla	ce, and due to the	cause(s) and manner stated.
	withi To th		29b. Signature and title of certifier	ompleted cause of death (Item 23	29c. Licens	e number 4607/	29d. [	Date signed (Month	2010
			30. Name and address of person who	ompleted cause of death (Item 23	Ba) (Type, Print)			4538 E	DMONDSON AVE
			IVARA A. ESÉGE	UNIVERSITY	1 CARE EDI	NONDSON	I VILL AGE	BALTIN	10KE MO21229
	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	A backer				

Registrar

2010

8:30 Р. м

Bertha Elizabeth Smith

Physician /Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hydiene.

Baltimore, Maryland 21215-0036

Phy /Mc

To the Hospital or Attending Physician: The law requires that the death certificate be exec within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Summit Park Nursing Home	Catonsville	Baltimore
ıl r	5. Social Security Number 215 58 0885 6. Sex 1 M 2 XF 7. Age (In yrs. last birthda 101 Yrs.	Months Days Hours Min. (Month,	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or		
tor		sville	10d. Inside City Limits 1 ☐ Yes 2 🖾 No
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
aD	1502 Frederick Road	21228	U.S.A.
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian,
þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ YaNo If Yes, Give Year or Dates:	1 □ Yes 2 🖪 No Specify:	Black, White, etc.  Specify: White
Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
dmo	College (1-401 5+)	omemaker	Own Home
Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middl	
10 B	Joseph Benesch	Josephine	•
	T	ling Address (Street and Number or Rural Route Num	nber, City or Town, State, Zip Code)
			, Maryland 21061
		osition (Name of Date ematory or other place)	20c. Location - City or Town, State
		ven Mem. Park 05/12/2010	
	agrano Transmort	4001 Ritchie Highway Ba	
	23a Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between
	Immediate Cause (Final disease or condition	TIA	Onset and Death
	resulting in death)  Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	(17	
	Cause. Enter Underlying Cause (Disease or injury		
Examilia	that initiated events resulting in death) Last c. Due to (or as a consequence of):		
	d		
2			
an/N	IF FEMALE: 23b. Was decedent pregnant In the past 12 months?  1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy	23d. Date of delivery
Physician/Medical	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
Ê	9 D ONKHOWN		
<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the		tobacco use contribute to the cause of death?
erec		1	Yes 2 No 3 Probably 4 Unknown
Completed		24a. Wa:	opsy prior to completion of cause of
	OF Western of made and all	pen 1 □Yes	formed? death? 2 No 1 Yes 2 No
Re	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only	
2	1 ☐ Yes 2 ☐ No	Nursing Home 5 Res	
	1 Matural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation	Work?  M 1 □ Yes 2 □ No	how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si		(Street and Number or Rural Route Number,
Se	4 Homicide determined building, etc. (Specify)	City or To	own, State)
ואובחוכשו	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, and due to the occurred at the time occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
ME	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
-	30. Name and address of person who completed course of death (New Co.) (7)	DOOD 6 148	NA7 10 2010
	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) PLACE SUITE 31	+ BATIMONE NO 21201
te ar	31. Date filed (Month, Day, Year) NAY 1 4 2010 32. Registrar's Signature	parker	

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Sevier State of Maryland / Department of Health and Mental Hygiene 1010 1- For State Certificate of Death Reg. No. Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Month Day Medical Examiner 1437 hrs May 8, 2010 J<u>ohn</u> <u>Kenneth</u> Sevier 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Josephs Hospital **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Director Months Hours 73 Country) MD 212.34.3412 1 M 2 F Yrs 12.05.1936 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore MD Towson permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 705 East Seminary Avenue 21286 U.S.A. 12. Was Decedent Ever in U.S. Funera 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, or items. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc 1 Never Married 2 Married White Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Commercial timore, MD 21215-0036 Electrician Construction 10 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Kenneth Charles Sevier Grace Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ Shirley Button/Friend 705 East Seminary Avenue, Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 05.13.10 Beltsville, MD Chesapeake Crem. Donation 5 Other Specify: 22. Name and Address of Facility AFA/Stephen D. Lohrmann, PA 21 Signature of Funeral Service Licenses Green Pastures Dr. Balto. Part I. Enter the disease, or complication failure. List only one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** Between Onset and /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician the burial -X UNPENDED AMENDE 33a, 27, PII, 23e, per ME g904 6/28/10 TT the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth for use as Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 Unknown Smoking, Pulmonary emphysema and cirrhosis Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? page 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 5 Pending 1 Yes 2 No death. Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be within 24 hours at To the Funeral I. determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 9, 2010 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Louise Scott 10 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Charles Village Baltimore na If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
S . C . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 7 4 1926 1 □ M 2 🛣 F Hours Min. Director 248-40-0560 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No MD na Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U S Α 856 Abbott Court 21202 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify. 3X Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b, Kind of Business Industry unk (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+)un Elementary/Seconday (0-12) Housekeeper unk Be be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ George Buchanan Ruby Wilson Page 1 and 2 should permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 Erdman Avenue Balto, MD 21213 Loretta Jackson-Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Oaklawn Cemetery 5-15-2010| Balto, MD 4 Donation 5 Other (Specify) Sign ture of Fundal Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final teas Pnysician disease or condition resulting in death) Medical onseque ce of **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 g 2 🗌 No g 🗌 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nunknown Records, been signated the should the 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 ☐ Yes 2 No certificate Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident Suicide 5 Pending 1 🔲 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) Medical 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 2010 57088 30. Name and address of person who completed cause of death 21202 CT. (0)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Ty

DRMICHAel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Location					10d. Inside City Limits
ARKVILLE					1 🗆 Yes 2 🖺 No
10f. Zip Code			10g. C	itizen of What Co	ountry?
21	234			U.S.A	A.
. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- an, etc.)	-	14. Race - Ame Black, Whit	
1 ☐ Yes 2X No	Specify:			Specify: W	HITE
edent's Usual Occup e kind of work done	during most of working		16b.	Kind of Business	Industry
DO NOT use retired) PLUMBE				PLUM	BING
ER	18. Mother's Name (Fi			surname) I <b>Z ABET</b> I	H MILLER
	and Number or Rural Ro		er. City o	or Town, State, Zi	p Code)
•	RY CT., AP		_		
osition (Name of	Date		<u> </u>	_ocation - City or	
matory or other pla CREMAT	ORY 5/15/	10	ВА	LTIMOR	E, MARYLAND
2. Name and Addre	ZEILER IN TERN AVEN	C. F	UNE	RAL HOI	ME 21231
	ng, such as cardiac or re			- , ,	Approximate
thmic	4				Interval Between Onset and Death
1 TT PACE					
ary s	yndrom	t		22	
rosis					
			- 1		
☐ Ectopic pregnan	CV			23d. Date of de	livery
Other (specify)				Month	Day Year
underlying course gi	ivon in Part I	00- Did			the cause of death?
underlying cause gi	venin Farti.			use contribute to	
		24a. Was			itopsy findings available
		auto perf	opsy ormed?	prior to death?	completion of cause of
00.5		1 Yes	2	√o 1 ☐ Ye	s 2 No
_ loth	lace of Death (Check on.			J. 13.00	
ent 3 DOA 000	4 ☐ Nursing Home			6 ☐ Other (Spec iry occurred	cify)
wor	k?   Yes 2   No	, Describe	riow inje	ny occurred	
treet, factory, office	28f.	Location ( City or To			ral Route Number,
estigation, in my opini	e, date and place, and do on, death occurred at the ne time, date and place, a	time, date	and plac	e, and due to the	cause(s) and manner stated
29c. Licens	e number		29d. D	ate signed (Mont	h, Day, Year)
De	054428			5/11/	D
, Print)	1 Square	- DR	3	aLTOI	nd 21237
66					
GINAL					

3. Time of Death

07 PM

2010

Baltimore

MARYLAND

9. Birthplace (State or Foreign

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	e Type or Pr					-		_	ole.	
		For State		State of M	larylan	-	artment of F rtificate of L		Mental Hy	•	16		15149
		Registrar  1. Decedent's Nam	e (First, Middle, L	ast)		Cei	runcate or L	Jeaur	2. Date of De	Reg. No eath	0.		3. Time of Death
Physicia Medic		Phy	llis	G. Surgi	ıy				Month MAy	1.0		ear 201	05:20 FM
Examin	er			ive street and number)	_			r Location of Death oa town		40	County of Harf		
Funeral		5. Social Security N	umber 6	. Sex 7. Ag		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9	9. Birthp	ace (State or Foreign
Director		215-60- Usual Residence of		1 □ M 2 🙀 F	5	55 Yrs.	Moritins	riours with.	June	26,	1954	Count	MD_
rland f show d at	ţō	10a. State	10b. County		10c. City	, Town or Lo	ocation					10	d. Inside City Limits
e Mary r 28a-i notifie	Direc	MD 10e. Street and Nur	HArf	ord ———		Jopp	atown 10f. Zip Code			10 0			1 Yes 2 No
with th 23a o ust be	Funeral Director			ress Cour	t			085		US	itizen of Wha SA	at Coun	ry?
death items ner mu	Fun	11. Marital Status		12. Was Decedent Armed Forces?		3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race -	America White, e	
s after al", or Exami	ed by	1 ☐ Never Marr 3 ☐ Widowed	ied 2 ☐ Marrie 4 ☐ <b>x</b> Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	No		1 ☐ Yes 2 🕱 No				Specify:		
2 hour "natur sdical	Completed	(Spe	15. Decedent's				dent's Usual Occup		kina	16b. k	Kind of Busir	ness Ind	ustry
/ithin 7 iene. r than the Me	Com	Elementary/Sec	onday (0-12)	College (1-4 or	5+)	life. D	OO NOT use retired) espersor			F	Retai	1	
filed w al Hyg d othe event,	Be C	17. Father's Name (	First, Middle, Las	*				18. Mother's Nam			Sumame)		
uld be d Ment marke natic e	10		t Surg						1 Luca				
d 2 sho alth an 27 is i		19a. Informant's Na Gilber	t Surg				ng Address (Street a						-
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	position	☐ Removal from State	Cé	lace of Dispo	osition (Name of	e)	Date	20c. L	ocation - Ci	ty or Tov	vn, State
it. Pagintment		4 Donation	5 Other (Spe	ecify)	Bay		Cremato		14/10		altim		
permit Depar Impor any ir once.		21. Signature of Fu	neral service Lice	nouls	h	22	2. Name and Addres  Connel	ss of Facility 30 Ly Funer	00 Mac	e Av	re. B	alt	O. MD 21221
		23a. Part 1. Enter t shock, or hea	the disease, or di rt failure. List of	mplications that duse y one cause on each lin	d the death	n. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Between
Physician/ Medical		Immediate Cause ( disease or condition resulting in death)		_ aCa	Vdi	ac	orlles	<u> </u>				N	Onset and Death
Examiner				Due to (or as	a consequ	ence of):	orles	live					vintes
n #	niner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate rlying	b. Due to (or as	a consequ	ence of):	9 11						
executed an and rial-transi	Examiner	Cause (Disease or that initiated event resulting in death)	S	c. Due to (or as	a consequ	ence of):	· <del></del>				*	_	
eath certificate be executed attending physician and for use as the burial-transit				d			·						
ertificat ling ph e as th	/Mec	IF FEMALE:		23c. If yes, outcome	of progna	201							
eath ce attend I for us	Physician/Medical	23b. Was decedent in the past 12 1 Pres 2	months?	1 ☐ Live Birth 4 ☐ Pregnant a	2 Feta	Ideath 3	Ectopic pregnanc Other (specify)	у			23d. Date of Month		ry Day Year
t the de by the stached	Phys	9 ∐ Unknown		9 Unknown									
law requires that the de has been signed by the je 2 should be detached	by	Part II. Other signif	DI CL	contributing to death I		iting in the L	underlying cause giv	en in Part I.			use contribu		e cause of death?
v requi	Completed								24a. Was		24b. Wer	e autop:	sy findings available
The lav	Som								auto perfe	psy ormed? 2 M/N	dea	rtocom th? Yes 2	pletion of cause of
ician: certific rector,	Be	25. Was case referre examiner?	ed to medical	Hospital:			Othe	ace of Death (Chec	k only one)				
g Phys er this eral di	e: To	27. Manner of Deat	1	28a, Date of inju	iry	28b. Time of	nt 3 L DOA 28c. Injury	4 □ Nursing Ho / at	ome 5 Resi 28d. Describe			Specify)	
tending leath. or: Aftu the fun	Certificate	1 Z Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigat 6 ☐ Could no	he		injury		? Yes 2□No					
l or Atl after d Direct I in by		4 Homicide	determine				eet, factory, office		28f. Location ( City or To			r Rurai I	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical			hysician: To the best of miner: On the basis of e									
the H thin 24 the Fi	Me		☐ Certifying N	urse Practioner: To the	best of my	knowledge,	death occurred at the	e time, date and pla	ce, and due to the	ne cause(	s) and manne	er as sta	ed.
7. w 6.		Signature and	Or certifier	20			29c. License	(0817)3	,	29d. Da	te signed (M	iontn, D	ay, 1 <del>0</del> ar)
		30. Name and addre	ess of person wh	o completed cause of c	leath (Item	23a) (Type, F	Print)			<del>&gt;-</del>	1 - 11	<u> </u>	21721
ナ '		Tayword (Monti		32. Figistr	ar's Signati	ure	Laoty	n. Divo	) 15a	140	2000 V	NO	21221
Stat Registra			WAY 14	2010	- o.g.iati	1 1	- 1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me g918 8-3-11 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year DANIEL STURGIS 4:32 pm MOY 10 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Harbor Baltimore 8. Date of Birth (Month, Day, Year) March 17, 1956 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 1 X M 2 □ F Maryland 219-70-5336 54 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location MD Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8720 Philadelphia Road 21237 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2x No 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) commercial house painter home improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Littleton Burrows Sturgis Margaret Catherine Hutchins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Sturgis/brother 1502 Barrett Road; Baltimore, Maryland 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Structure Sicensee Wade <sup>22</sup> State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part n Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lactic acidosis One day disease or condition resulting in death) Due to (or as a consequence of): failure HEPatic unknown Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury CERTIFICATION APPROVED BY MEDICAL EXAMINER unknown liver diseas e Alcoholic that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Kidney Chronic 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Metformin autopsy performed 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

be executed P.O. Box 68760, Division of Vital Records,

Examiner burial-tran physician Physician/Medical use as the signed by the a should page 2 After this certificate il or Attending Physician: after d.a.h. Director After this certifica funeral he filled in by within 24 hours a

**Physician** 

/Medical

Examiner

Director

ş

Completed

Be

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar mast be notified at

death with

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" " any injury or other traumatic events."

**Physician** 

Examiner

/Medical

þ Completed Be Certification: To

Medical

27. Manner of Death 1 Natural

> 3 ☐ Suicide 4 Homicide

> > (Check only one)

29b. Signature and title of certifier

29a. Certifier

6 ☐ Could not be determined

MAHOIS SARRAFI,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES CO

29d. Date signed (Month, Day, Year) May, 10,2016

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HARBOR HOSPITAL, 3001 South Hanover St. Baltimore

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

M.B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KOBERT 4:50-a 05 -2010 W. 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Chapel Hill Nursing Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, July 16 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 D **Funeral** Min. Months Days Hours 1 XM 2 ☐ F 208-22-1826 88 Yrs. PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Pedical Examinant It. Confided and once. MD Carrol1 Sykesville 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7426 Village Road Apt. 208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) firefighter fire protection 17. Father's Name (First, Middle, Last)
Curtis L. Taylor 18. Mother's Name (First, Middle, Maiden Surname) Be Clare Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7426 Village Rd., Apt. 208, Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) Sadie Lee Taylor (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Nurial 2 □ Cremation 3 □ Removal from State Crest Lawn Memorial 5-13-10 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Prige Haight Heusent P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ROSTA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EMENT! Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 687607 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown spital or Attending Physician: The law requir ours after death.

Peral Director: After this certificate has been si filled in by the funeral director, page 2 should Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 2 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier MV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anre L. Vellanners Grys 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

10-03621

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Linda	a M. Taylor	•	1- For State Registrar	tate of Maryland		rtment of tificate of		d Mental	- 0	Reg. No	2010	15152
Med	Physic lical Exam		Decedent's Name (First, Midd     LINDA M	lle,Last) TAYLOR				-	2. Date of De Month May 10, 2	Day	Year	3. Time of Death 2139 hrs
			4a. Facility Name (if not instituti		r)	4	o. City, Town, or	Location of De			c. County of Dea	
	Funeral		Sinai Hospital  5. Social Security Number	6. Sex 7. A	ge (In yrs. las	st birthday)	Baltimore If Under 1 Yea	r If Under 24	Hrs. 8. Date of B	irth (MM	N/A 1/DD/YYYY) 9. Bi	irthplace (State or
	Director		212-48-8991 Usual Residence of Decedent	1 M 2 X F	6	3 Yrs.	Months Day		Min. 2/15/		Fore	
	/ any		10a. State 10b. County		10c. City, T	Town or Location	n					10d. Inside City Limits
	Maryland 28a-f show any d at once.	ţō	MD N/A	1	BAL	TIMORE						1 X Yes 2 No
	ne Mary or 28a fied at	Director	10e. Street and Number 5723 SIMMONDS	AVENUE		1	10f. Zip Code			10g. Cit	tizen of What Cou	untry?
	with the ms 23a be not	eral	11. Marital Status	12. Was Deceder					( Specify Yes or N	0-		rican Indian, Black,
	er death , or ite	Funeral	1 Never Married 2 M	1 Yes	X No		s, specify Cuban		erto Rican, etc.)		White, etc.	r
	urs afte tural", amine	d by	3 Widowed 4 X Div 15. Decedent's Education (Spe	orced If Yes, Give Year or Dates: cify only highest grade co	mpleted)		es 2 No		of work done	16b.	Specify: WI Kind of Business	HITE //Industry
•	66 n 72 ho an "na ical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	ŭ	st of working life.	DO NOT use	retired)			
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Som	17. Father's Name (First, Middle	Last)		HOMEM		18.Mother's Na	ame (First, Middle,		WN HOME	
	21215-0036  Uld be filed within 72 hours after death with the Maryland Mental Hygiens  Marked other than "matural", or items 23a or 28a-f sho  c event, the Medical Examiner must be notified at once.	Be (	<u>JU</u> LIUS	LIVINGS	TON	_	ľ	MIRIAN	1		NATHAN	
Ġ	nd N is a stic	To	19a. Informant's Name/Relations IRIS LITTMAN/			1			or Rural Route Nu			
-	re, MI s 1 and 2 s of Health a If item 27		20a. Method of Disposition			ace of Dispositi	on (Name of cen	netery.	OR DRIVE		Location - City or	
	Pages Pages nent of ant; It or othe		1 X Burial 2 Cremation 4 Donation 5 Other S			MUNO CE	N⊳iaGHIZU METERY		13/2010	В	ALTIMORE	E. MD
2	Baltimore, permit. Pages 1 and Department of Heal Important; If item injury or other tra		21. Signat & of Funeral Service	ticensee		22. Na	me and Address	- C C 1004	SOL LEVIN	_		
	Physician	П	23a. Part I. Enter the disease, or failure. List only one cause	complications that cause	d the death. D	o not enter the	mode of dying,	IERSIUM such as cardia	ON KUAD,	PIK rest, sho	ESVILLE, ock, or heart	Approximate Interval
	/Medical Examiner		Immediate Cause (Final disease	a Complica		of liv	er cirrl	nosis				Between Onset and Death
			or condition resulting in death)	Due to (or as a cons	sequence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):							
	ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
	bu, te be executed sysician and burial - transit	edical	XUNPENDED	d AMENDED								
9	cate be	/Med	IF FEMALE:	AMENDED 23a, 27	permE me of pregna	<b>,</b> g903 .	5/25/10	TT		236	d. Date of deliver	y
Ċ	EOX DS/DU, edeath certificate be the attending physic ed for use as the bur	cian	23b. Was decedent pregnant in the past 12 months?	I LIVE DITTI	t time of death	, - 🖂	death 3 (	Ectopic preg	gnancy		Month [	Day Year
0	he death	Physician/M	1 Yes 2 No 9 V Uni	9 Unknown								·
0		Ď	Part II. Other significant conditi	ions contributing to deal	n but not rest	uiting in the und	leriying cause gi	ven in Part I.				the cause of death?
7	w requir	Completed					-	-	24a. Was			itopsy findings available
Č	The law icate has page 2 si	m o								rmed?	death?	
1	ician: The sector, page	Be	25. Was case referred to medical examiner?	Hospital:		R/Outpatient 3		of Death (Chec				
7, 30	ing Physic After this uneral dir	5	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry 2	8b. Time of Inju		at Work?	sing Home 5 28d. Describe		nce 6 Other	r.
	ttendir death. ttor: A	atio	1 X Natural 5 Pend 2 Accident Inves	(Month, Day.) ing stigation	ear)		1 Y	es 2 No				
	DIVISION OF VICE RECORDS, Hospital or Attending Physician: The law requir At hours after death. Funeral Director: After this certificate has been s rely filled in by the funeral director, page 2 should t	ertification:		d not be mined 28e. Place of Ir	njury - At hom	e, farm, street,	factory, office bu	ilding, etc.	28f. Location (S or Town, S		nd Number or Ru	ral Route Number, City
V	the H hin 24 the Fu	Medical C		ysician: To the best of m								
	To COL	¥	29b. Signature and title of certifie	and manner stated.			29c. License	number		29d. [	Date signed (Moi	nth, Day, Year)
			(med)				O.C.M	1.E.		Мау	11, 2010	
	ļ		<ol> <li>Name and address of person Ana Rubio MD. Ass</li> </ol>	who completed cause of c istant Medical Exan			eet, Baltimor	e, MD 212	01			
			31. Date filed (Month, Day, Year)		r's Signature	. /						·
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			For	State of Ma	aryland					lental Hyg	giene ,	2010	15153
		_	State Registrar			Cer	tificate of	Death	)	F	Reg. No.	2010	10100
P	hysicia	n/	1. Decedent's Name (First, Middle		Chi					Date of Dea     Month	th Day	Year	3. Time of Death
	Medic	al	RICHAR		GEL				(5	Month 0.5	DB	2010	18:04pm
<i>)</i>	Examin	er	4a. Facility Name (if not institution,	_	+-1		4b. City, Town, Baltin		n of Death		4c. C	ounty of Death	
	uneral		Good Samar 5			st birthday)	If Under 1 Year		er 24 Hrs.	8. Date of Birth	1	g. Birtho	place (State or Foreign
	rector		216-36-8520	1 <b>≥</b> M 2□F	69		Months Days	Hours	Min.	(Month, Day, Dec	$04^{r}$ ,	1940 <sup>C</sup> Ma	ryland
	<b>A</b>		Usual Residence of Decedent										
yland	f sho	tor	10a. State 10b. County			Town or Loc						1	0d. Inside City Limits
Mar	28a- notifi	ire		ltimore		Parkvi							1 Yes 2 No
th th	t be	Funeral Director	10e. Street and Number				10f. Zip Code 212	31				en of What Cour nited S	•
ath w	ms 2 mus	nue	2917 Lingano:	12. Was Decedent Ev	ver in U.S.	13. V	Vas Decedent of		Origin? (Spe	cifv Yes or No-		. Race - Americ	
ं के	or ite	уF	1 Never Married 2 Marr	Armed Forces?	_	If	Yes, specify Cub	oan, Mexic	an, Puerto	Rican, etc.)	'	Black, White,	
rs af	ıral", Exa	edt	3 Widowed 4 Divorced	If Voc Civo		1	☐ Yes 2 N	o Specii	fy:		Sp	pecify:	White
5-6 2 hou	"natu	Completed by		nt's Education st grade completed)			ent's Usual Occu		ost of worki	na	16b. Kind	of Business Inc	dustry
Fi : 12	than le Me	mo;	Elementary/Seconday (0-12)	College (1-4 or 5-	+)	life. DO	O NOT use retired	d)			D.	egan's	Tavern
N with	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, L	aeti		ва	rtender	19 140	thor's Name	e (First, Middle, I			1avelii
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mantal Hydiene.	ked o	일	William Vog					10. 1010	Cathe		hoff	marro	
<b>V</b> buot	mar		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Stree	t and Num	ber or Rura	l Route Number,	City or To	wn, State, Zip (	Code)
	f item 27 is marked or r other traumatic ever		Robert Pawlo	wicz /Newphew		29	17 Ling	anore	Ave.	Parkvi	lle,	MD 212	34
<b>Baltimore,</b> permit. Page 1 and Department of Hea	r other		20a. Method of Disposition 1	2 Demoved from State			sition (Name of natory or other pla	ace)	(	May 1	20c. Loca	ation - City or To	own, State
Page 1	ant: I		4 Donation 5 Other (S				ake Cre		У	2010	′ B	eltsvill	e, Maryland
<b>Balt</b> i permit. Departr	Important: If it any injury or o once.		21. Signeture of Funeral Service L	icensee	10144	(3) 22	. Nam <b>e zreinad</b>						
م ق	- 6 6 E	Ш	tydable	Kellen-								on Maryl	Land 21286
			23a. Part 1. Enter the disease, or shock, or heart failure. List of			. Do not ente	r the mode of dy	ing, such a	as cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	sician/ ledical		Immediate Cause (Final disease or condition resulting in death)	- a. Pheur									Onoot and Doddi
	aminer		resulting in deality	bue to (or as a			five pu	1000	nie.	dicea	10,		
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a			100 120	ringr	J	C113 E40			
nted	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events									201	
exec	an an rial-tr	EX	resulting in death) Last	Due to (or as a	conseque	ence of):							
. <b>68760</b> certificate be executed	physician and s the burial-transit	dical	30	<b>d</b>									
687 sertifica	ing p e as t	/Me	IF FEMALE:	23c. If yes, outcome of	of prognan								
<b>Box (</b>	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2	2 🗌 Fetal	death 3 [	Ectopic pregnal Other (specify)	ncy			23	d. Date of deliver Month	ery Day Year
<b>n</b>	been signed by the attending pl should be detached for use as t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	g Unknown	time or de	5411 5 =	other (apecity)						
cords, P.O. I	deta	y Pł	Part II. Other significant condition	ns contributing to death bu	ut not resu	Iting in the u	nderlying cause (	given in Pa	rt I.	23e. Did to	bacco use	contribute to the	ne cause of death?
uires	n sigr Ild be	Completed by	coronary dr	tery disea	se,)	eep u	renous.	thron	n bosil	5 1 🗆 Y	′es 2 □	No 3 Pro	bably 4 Unknown
w req	s bee	plet				/				24a. Was a		24b. Were auto	psy findings available impletion of cause of
The la	ate ha	, m								perfor	med?	death?	
ian:	ctor, i	Be (	25. Was case referred to medical examiner?				26.	Place of De	eath (Check	only one)			
hysic	this ce al dire	၉	1 Yes 2 No			R/Outpatien	t 3 🗆 DOA			me 5 Resid	-		<u>)</u>
ing F	After 1	Certificate:	27. Manner of Death Natural 5 Pendin			28b. Time of injury		uryat rk? ∐Yes 2 l		28d. Describe ho	ow injury o	occurred	
SIOI vitteno death	y the	titi	2 Accident Investig	not be 280 Place of Injur	rv - At hon	ne. farm. stre				28f. Location (Si	treet and I	Number or Rurai	I Route Number.
Division of Vital Records, tal or Attending Physician: The law requires after death.	Direct of in b		4  Homicide determ	building, etc.	(Specify)	, , , , , , , , , , , , , , , , , , , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town			,
Spita hours	ineral d fille	lical		Physician: To the best of r									
DIVISION Of VITAI RECC To the Hospital or Attending Physician: The law within 24 hours after death.	the Fu	Medical	only one) 3 Certifying	xaminer: On the basis of ex Nurse Practioner: To the b			leath occurred at	the time, da	ate and plac				
To t	To t		29b. Signature and title of certifier	44 h				se number			29d. Date	signed (Month,	Day, Year)
			20011th	MD			I NE	500	) U		05	108/2	-ULU
			30. Name and address of person v		ath (Item)	(Type, P	rint) n'fan ho	8pital	1 Loc	A Raven	Blvd	Balt	in pro
	Stat	e	31. Date filed (Month, Day, Year)	32. Registral	, ,			-/		NI)	212	9	
	Registra		MAY	4 2010		A	houles	•					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Joshua Worthington Weatherlev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blakehurst Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. Feb. 20 Maryland **Director** 96 216-05-1256 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2🏋 No Maryland Baltimore Towson 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 West Joppa Road 21204 U.S.A. items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. Completed by and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 1941 – 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Proprietor Years Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Frank Weatherley Mary Offutt Worthington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Kent W. Weatherley (son) 577 Woodbine Ave. Towson, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 5-17-10 Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home
6500 York Road Baltimore, Mary Signature of Funeral Service Licenses any 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) hNMIC OBSTRUCTUE Medical Due to (or as a consequence of) Examiner YEARS OMESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed this certificate 2 No 1 Yes 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one. Be Hospital: Other: 2 No 1 Yes ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann⇒ of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred After injury 5 Pending ithin 24 hours after death.

• the Funeral Director: Af

ompleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 05076 en 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

YORK

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 5:20 P. M Elsie M. Wheeler 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Anne Arundel Genesis Eldercare Hammonds Lane Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours (Month, Day, Year) Mary land 213 28 5887 100 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Anne Arundel Maryland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Harding Road 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Helmstetter Louise Rienhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21060 Clinton Wheeler Jr. / Son 16 Harding Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Baltimore, Maryland 05/13/2010 Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. . Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician eskemin disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause (Disease or linjury Date to for as a porsequence of Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown been signed by 1 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **29**No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending n 24 hours after death.

Funeral Director: A pleted filled in by the fu 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical 29a. Certifier 🚈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D53465 30. Name and ad ess of person who completed cause of death (Item 23a) (Type, Print) Opkwood Rd. MA Jude

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

barks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mallory Reynolds Warner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month May 6. Mallory Reynolds Warner **Medical Examiner** 2205 hrs 2010 May 7, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 28700 Head Quarters Drive N.E. Flintstone Allegany 9. Birthplace (State or Foreign Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Months Days Hours Min Director 578-62-7527 59 May 1, 1951 1 4M 2 F Country) D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No 28a-f show **Alleghany** Flintstone l other than "natural", or items 23n or 28a-f sho the Medical Examiner must be notified at once. with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14200 Elbinsville Rd. United States 21530 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No- Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes White Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify. <u>Á</u> 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " 5+ Architecture Architect 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Brainard Henry Warner III Mildred Keeler Jonathan Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ပ Brainard H. Warner IV /Brother 3585 Hamlet Place, Chevy Chase, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Chesapeake Crematory 5/10/2010 Beltsville, MD Donation 5 Other Specify: -21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00382 Rapp Funeral and Cremation Services 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the production of the control of the con 20910 Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Contact Shotgun Wound of Neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and I be detached for use as the burial - tran Physician/Medical AMENDED #2perME, G908, 10/25/2010, WS UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed s been s 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of s certificate has rector, page 2 s has performed? death? 1 ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: å examiner? Hospital: 1 Inpatient 2 Other 4 Nursing Home 5 Residence 6 🗸 Other: Scene this ER/Outpatient 3 DOA 1 🗸 Yes ို 28a. Date of Injury (Month, Day Year) May 7, 2010 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self 1 Natural 0000 hrs within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 1 Yes 2 ✔ No 2 \_\_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide 6 Could not be or Town, State) 28700 Head Quarters Drive, Flintstone, MD determined (Specify) Woods Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9050 O.C.M.E. May 8, 2010 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registra

**ORIGINAL** 

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month V 1750 Wach atherine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death monyland how. of N/A Hmore 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕮 F Months Days Hours Min. (Month, Day, Year) Country)
Maryland Director 217-26-7671 80 Jan. Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4721 Mountain Rd. 21122 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: White Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oliver Stallings Nellie 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. 8543 Colony Cr. Easton, Md. 21601 Charles V. Wachter (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Magothy Church Cem. 5/17/10 Pasadena, Md. 21. Signature of Funeral Survice Lizer 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the disease, or composhock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Hear disease or condition Medical resulting in death) Examiner COLONOL Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Was decedant in the past 1 month of the Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ disect 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 2 🗌 No 1 Tes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident 3 Suicide Investigation Could not be 2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

Division of Vital Records, P.O. Box 68760 within 24 hours a To the Funeral I

> State Registrar

29a. Certifier

(Check

31. Date filed (Month, Day, Yea

MILES

of death (Item 23a) (Type, Print)

mo

rar's Signature

Ruse

32. Regis

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

25 S Green Sp

29d. Date signed (Month, Day, Year) May 12 201

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 11:58 AM Carolyn Webb Α. 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore na Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 12-27-1947 9. Birthplace (State or Foreign **Funeral** Days Hours Director 217-54-0530 62 MD Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items 23a or 28a-f shor lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2021 E. 31st Street 21218 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Black Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry na (Give kind of work done during most of working life. DO NOT use retired) na Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William A. Webb Emma L. Pritchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance McLaughlin 6 Six Point Ct Randallstown, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 5-15-2010 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H Signature of Funeral Service Licenses 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate makes Enter Underlying Examine Cause (Disease or iinjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 ☐ Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown been signed by 1 should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner?

1 Yes 2 No I director, Be 26. Place of Death (Check only one) Hospital: Other: ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of After 28c. Injury at 28d. Describe how injury occurred injury 1 Matural 5 Pending after death Director: A I in by the fi 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

the Hospital or Attending Physician: The law requires that the death certificate be executed the Funeral Directory filled in by the within 24 ho

To the Fune

completed fi

> State Registrar

(Check only one) 29b. Signature and title

address of person who completed cause of death (Item 23a) (Type, Print)

201 32. Registrar's Signature

MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00066212

East University Parkway - Baltimore, maryland 21218

29d. Date signed (Month, Day, Year)

10,2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VIVIAN WOODWARD MAYTH 10<sup>ay</sup> 2010 6:26 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MORNINGSIDE ASSISTED LIVING PARKVILLE . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Month, Day, Year) 1 M 2 🖼 F PENNSYLVANIA 173-14-8749 89 Director Usual Residence of Decedent 10b. County 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 X No MD BALTIMORE PARKVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a o Examiner must be Funeral 8719 LACKAWANNA AVENUE 21234 USA 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 Divorced Specify: "natural" Completed WHITE the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ital Hygiene. ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) STORE MANAGER RETAIL 12TH GRADE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H I item 27 is marked ot r other traumatic ever ဂ္ CARL A. PALMQUIST HILLEVE ENGELSTAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau HARRY WOODWARD/SON 452 GLENMAR RD. APT. C1 GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
DULANEY VALLEY MEM. 1 X Burial 2 Cremation 3 Removal from State 5/19/2010 4 ☐ Donation 5 ☐ Other (Specify) COCKEYSVILLE, MD 21. Sign, ty e of Funeral Service Icensee MO 1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset nd Death halstag Immediate Cause (Final Physician disease or condition Medical resulting in death) (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy 2 🗌 No 1 🗌 Yes Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No ASSISTED 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending work? 1 Natural 5 Pending injury 2 2 No Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certiflei (Check

Registrar

29b. Signature an

ital DR.

29d. Date signed (Month. Day.

INTHICUM,

Surrifying Nurse Practioner: To the best of my knowledge,

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April Sherrill Henry Agee 28, 7:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Solomons Nursing Center Calvert Solomons Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 - F **Director** 447-12-3840 89 0173071921 OKTanoma Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Calvert Lusby 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 John Hanson Drive 20657 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3√ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7; Health and Mental Hygiene. Iem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Appliance Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Alexander Agee Beatrice Ham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack H. Agee / Son 412 John Hanson Drive, Lusby, Maryland 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of P Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 4/28/2010 Alexandria, Virginia Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due o (or as a sequence of) Examiner Sequentially list conditions, to a second course. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident
3 Suicide Investigation 1 Yes 2 No the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Berg, MD110 Hospital Rd., Suite 310, Prince Frederick, Maryland 20678

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MildREd DANIEITA APRIL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEDICALCENTER SAINT JOSEPH TOWSON BALTIMORL 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🛛 F Days Months Hours Min. (Month, Day, Year) Director MARYLANG Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits BAltimore 1 Yes 2 No MARYIAND 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 1008 Woodson Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: white Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 0 THEANT INFANT 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eliseo TORRES JOSELINE BATRES 19a. Informant's Name/Relationship (Type, Print) (PARENTS) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elisec TORRES + Juseline Woodson Baltimore MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State injury or 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY RECEEMER CEMETERY April 21,2010 BALLMORE City any in once. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Tewson, Md. Jeseph Medical CENTER OSIER 7601 2,204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) **Examiner** CONGENITAL RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exam attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Day Month Year Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident **Director:** Suicide 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D41343 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MICHAEL

31. Date filed (Month, Day, Year)

M.D

32. Registrar's Signature

7601 OSLER DRIVE TOWSON MARYLAND 21204

LANGBAUM

10-03513 Clinton Gerald Ball Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Clinton Gerald Ball	1- For State Registrar	State	of Maryland		rtment of tificate of		nd Me			Reg. No.	20	0	15162
Physician/ Medical Examiner		me (First, Middle,Last) ON GERAL							2. Date of De Month May 6, 2	Dav	Year	3.	Time of Death 1233 hrs
	4a. Facility Name 5 Garrett A 5. Social Security			er) Age (In yrs. Ia		La Plata			8 Date of F	С	harles		lace (State or
Funeral Director	528-96	5-4387 <sub>1-</sub> X	M 2 F		51 <sub>Yrs</sub>	Months Da	ays Hou		12-1			oroign	<sub>ry</sub> UTAH
d sow any	10a. State	10b. County  CHARLE	s	10c. City,	Town or Locati	on ALDORF	,		٠				Od. Inside City Limits Yes 2 XNo
the Maryland a or 28a-f she liffed at once	10e. Street and N	I lumber ARKSDALE	λυσ			10f. Zip Code	602			10g. Citiz	zen of What	Country	?
death with or items 23. must be no	11. Marital Status 1 Never Ma	ried 2 🔀 Married	12. Was Deceder Armed Force	s? 2 NoN 2	AVY If Y	s Decedent of Hes, specify Cub	lispanic O an, Mexica	an, Puerto F		lo-		tc.	ITE
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21215-0036 with be filed within 7 Mental Hygiene. marked other than ce event, the Medical FO Be Comple	GERO	e (First, Middle, Last) OLD DALE					SI	HARON	(First, Middle,	CHEL	L		
MD 21 d 2 should dt 2 should lth and Me n 27 is ma n umatic ex	DORIS	Name/Relationship (Ty BALL–SPO			227	Address (Str	ALE	AVE.	. WALI	OORF	,MD.	20	602
Baltimore, MD permit. Pages 1 and 2 sh Department of Heath and Important: If item 27 is injury or other traumat	4 Donation	Cremation 3 Other Specify:	100	State AT	Place of Disposi rematory or oth LANTIC	er place) CREMA	TOR	Y 5-8		GL			
Balt permit Depart Impor injury	21/	the disease, or compli	<u></u>			ame and Addre YMOND  PLATA							
Physician /Medical Examiner	23a. Part I. Enter failure. List of Immediate Cause or condition resu	only one cause on eac (Final disease a	cations th <del>at c</del> ause h line. Hyperten ue to (or as a con	sive o	cardiov				respiratory ar	rest, sho	ck, or heart		Approximate Interval Between Onset and Death
ted Insit	Sequentially list of if any, leading to cause. Enter Un (Disease or injury	conditions, bimmediate Derlying Cause that initiated c	ue to (or as a con	sequence of	):								
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/Mh									1 Yes		prior deat	to comp	sy findings available pletion of cause of
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Division o vithin 24 hours after death. To the Funeral Director: After completely filled in by the fune	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e Place of I	Injury - At ho	me, farm, stree	t, factory, office	building,	etc. 2	28f. Location ( or Town,		nd Number o	Rural I	Route Number, City
To the Hosy within 24 hd To the Fun completely:		Certifying Physicia Medical Examiner:		amination an									iuse(s)
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aryland show	ŗ	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town	or Location		7				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Ba-f	Director	MD		ltimore			Free		1a		10a Citi	zen of What C	ountry?
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eath v	eral		есктеу	sville Roa		S	13 Was Decer	lent of H		ecify Yes or No		14. Race - Am	erican Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Everture resist be realthed at once.	by Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>		Armed Forces?			If Yes, spec		lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, Whi	
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Physician /Medical		shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List o (Final on	only one cause on each li	ne.	rdi	el in		rction				Interval Between Onset and Death
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iclan: Th certificate ector, pag	BeC	25. Was case refer	rred to medical						26. Place of Dea				
nystci nis ce direc		examiner? 1 ☐ Yes 2 🔀	No	Hospital: 1 ☐ Inpati	ent 2	ER/Out	patient 3 D	Oth Oth	ner: 4 🗆 Nursing H	ome 5□Res	idence (	6 □Other (Sp	pecify)
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one)		g Physician: To the best Examiner: On the basis of and manner st	of examina								
Vithii To th	ž	29b. Signature and	title of certifier		011	2 1 V		c. Licens	se number		29d. Da	te signed (Moi	nth, Day, Year)
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		30. Name and add		who completed cause of	death (Iter	n 23a) (	Type, Print)	H CH	HARLES (	ST. BAIT	TIMO	DRE M	ID 21204
Sta	te	31. Date filed (Mor			rar's Signa		ha v	1	y	.,			
Registr			rire!	- 2010		13.	Market Contract						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 040nt 29-2090 Year James Leroy Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harkord 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07 Months Days 930 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10XM 2□F 216-34-2097 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or Iteme 23e or 28e-f ebo treumatic event, the Modical Examiner must be notified at Maryland | Harford Havre de Grace 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Darlington Road 21078 United States of America Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 D(Yes 2 D No If Yes, Give 1956-1989 Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leroy Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ada Ruth Brooks (wife) 114 Darlington Road, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛱 Burial 2 □ Cremation 3 □ Removal from State Rock Run Cemeterij Department of Importent: If eny injury or once. 05-03-2010 Havre de Grace, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 123 S Washington St, Havre de Grace, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physicien end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 No After this certification, I Be 25. Was case referred to medical examiner? 26. Place of Death Check only he Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 21 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of ate of Injury (Month, Day Year) 27. Manper of eath 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No filled in by the fo 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32. Ragistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janice Marie / Month Byrd 2018 316 Medical tori 4a. Facility Name (if not institution, give street and **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PAINSULA Kes/ONAL HICOMICO SINISHILL If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days 220-52-8359 Hours 61 Min 03/22/1949 Director Maryland Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho at 10a. State 10b County Director 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified Maryland Wicomico 1 X Yes 2 ☐ No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 200 Civic Ave. 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 K Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) dry cleaner dry cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James N. Phippin Doris Phippin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 313 E. Church St., Hebron, MD 21830 Donald Byrd Jr/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o cemetery, crematory or other pla Springhill Memory Gardens 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4 30 2010 Hebron, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 dompon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HADE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has perform within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 1 Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No ၉ 1 Tes Other 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifile 9 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

31. Date filed (Month, Day, Year)

APR 30

to056197

moll st. Salisbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month **Physician** April 24, Esther 03:41A Mae Bowser /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F Months Days Hours Director 200-28-3342 92 January 19, 1918 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at 28a-f show Y Yes 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23075 Hollywood Road 20650 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes A No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Waynesboro Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Weslev Hamm ပ Blanche Mae Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Bowser PO Box 1008, Leonardtown, Maryland 20650 20a. Method of Disposition
1 → Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) April 30, 2010 Martensburg, Martinsburg Mennonite Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Lochstampfor FUnearl Home, Inc. Skinative of Funeral Service Licensee M-00849 and 48 S. Church St., Wayenesboro, PA 17269 holam 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Physician tailur disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumon Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consecusion of: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, Completed by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No o 9 Unknown 9 Unknow σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 1 ☐ Yes 1 ☐ Yes Physician: ours after death.

neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13H-6 190 31. Date filed (Month, Day, Hear) 32. Redistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#10lopenFH, 4/30, 10/BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Time of Death 9:30A 2. Date of Death Physician/ Catherine Burton Appunil 26,2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Gaithersburg Examiner Montgomery 8815 Primula Drive Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. . Social Security Number 228-12-5462 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛂 F Days Months Hours 0574474920 Virginia **Director** Usual Residence of Decedent 28a-f shov 10b. County Montgomery Motgomery 10c. City, Town or Location Gaithersburg 10a. State 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗆 Yes 2 🖁 No MD 10e. Street and Number 10f. Zip Code 82 10g. Citizen of What Country? Funeral 8815 Primula Drive United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or iten edical Examiner r þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, Give kind of work done during most of working nd Mental Hygiene. Elementary/Seconday (0-12) Private Duty Nurse College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last)
John Hunter 18 Mother's Name (First, Middle, Maiden Surname) Ioner Boone ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8815 Primula Drive Gaithersburg, MD Wellington Burton (Son) and 2 s Health item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State Southview Cemet. Franklin, Virginia 1,2010 May 4 Donation 5 Other (Specify) Johnson&Sons Funeral Home ne and Address of Facility John Son & Son Fune Lat 110. South Main St., Franklin, VA 23851 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Pulmonary Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No ò detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Fibrosis 23e. Did tobacco use contribute to the cause of death? Completed by the funeral director, page 2 should be 2 X No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has 2 🗓 No After this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🔀 No Other: မ 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number April 26, D39793 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Christopher J.

31. Date filed (Month, Day, Year) APR 3 0 2010 Mays, MD

32. Registrar's Signature

18111 Prince Phillp Drive, Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month APR 8:00 PM SAMUEL WALKER 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 1000ARD COUNTY GUAVERAL Howard INTEPITA COZUMBIA 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 🏹 M 2 🗆 F Months Davs Hours Min. Feb. 13, 1933 Washizngton, DČ 218-30-3474 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits 10h Counts 10a. State Director 1 ☐ Yes 2 No Fulton Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20759 United States 7434 Cherry Tree Drive 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1952-1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) USDA Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o Anne Griffith Samuel W. Beall, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7434 Cherry Tree Drive Fulton, Maryland 20759 19a. Informant's Name/Relationship (Type, Print) Donna Briggs Beall -wife 1 and 2 s of Health item 27 i or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State St. Johns Episcopal Cemetery 4/30/2010 Beltsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bonard V. Borgwardt Funeral Home, rold V 15 or 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) RALLURZ RESPIRATING Physician, ACUTE Medical Due to (or as a consequence of): Examiner EMPYEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami PMZUMUNIA that initiated events resulting in death) Last and-trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death the Unknown 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HOAD AND NEUR CANZER 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? UESOPHACISAL CANZER. 24a. Was an nas autopsy MSBOS TOSK 1 Yes 2 No certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 1 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🛂 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APR 25, 2010 D36974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 CHARTER DRIVE 21044 O. NYANTON NO COLUMNIA MO DAVIO

Registrar

31. Date filed (Month, Day, Year)

28

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#23a,pt1,perPHYS,G903,5725/2010,WS
State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#20bperFH,5/11/10,BM,McCo Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2010 Month April Physician/ 21 5:15 Sylvia Bassoff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral New York Year) 19<u>14</u> 1 M 2 TXF Months Days Hours Min. (Month, Day, arch 2 96 Yrs Director 083-10-8187 March Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Silver Spring MD Montgomery 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? Funeral 20902 10315 Insley Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White, etc. 1 Never Married 2 Married þ nan "natural", o Medical Exan If Yes, Give Year or Dates 1 Yes 2 No Specify: Caucasian 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Homemaker Own Home other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy.
Important: If item 27 is marked other
any injury or other traumation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 Kate Rosenberg Joseph Perlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Bassoff, Daughter Hyattsville, 5302 41st Place. MD 20781 20a, Method of Disposition 20b. Place of Disposition (Name of 29-2010 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Brentwood, Maryland Ft. Lincoln Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. In fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ OAYS-4 Days SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner URWARY Trad Infector Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day Month Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? this certificate 2 No 1 Tes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After work?
1 Yes 2 No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the To the within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number HOO 657661 4/21/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deborah Stein, D.O. Hospitel Montgomery Genera 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signat

28 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygi	iene	1 1 7 0
			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Death	eg. No. ZUIU	131/0
	Physicia		Lois Shaw Berkman		Month	Day Year 5. 2010	3. Time of Death 6:20 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Deat	
1			Casey House	Rockville		Montgome	ry
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 ☒ F 72 Yrs.	If Under 1 Year If Under 24 Hrs  Months Days Hours Min.	(Month, Day,	Year) Co	thplace (State or Foreign untry New York
-	3		Usual Residence of Decedent		Sept 7,	1937 I	New Tork
	yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	r 28a notifi	Dire	MD Montgomery Montgom	ery Village			1 🗆 Yes 2 🔀 No
	filed within 72 hours after death with the Maryland the Hygiene. Hygiene. A chart with the matural," or items 23a or 28a-f show event, the Medical Examiner must be notified at.	by Funeral Director	19112 Brooke Grove Drive	20886		Og. Citizen of What Co United Sta	*
	items	Fune		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame	rican Indian,
99	after o I", or kamin		1 Never Married 2 Married 1 Yes 2 K No 3 Widowed 4 Divorced Yes Give	1 ☐ Yes 2 X No Specify:	o Rican, etc.)	Black, White Specify: Wh	e, etc. Lite
Ş	natura ical E	Completed	ical of Dates.	edent's Usual Occupation		16b. Kind of Business	
2 2 2	in 72 l e. nan "r Med	dmo	(Specify only highest grade completed) (Give	kind of work done during most of wor DO NOT use retired)	rking	iou. King of Business	industry
2	d with lygien ther th	Be Co	12	Estate Agent		es. Real E	state
anc	oe file antal ⊬ ced of c ever	To B	17. Father's Name (First, Middle, Last)  Nathan Schwartz		me <i>(Fir</i> st, <i>Middl</i> e, <i>M</i> a te Levy	aiden Sumame)	
ary Z	nould I nd Me s marl umati			ing Address (Street and Number or Ru		City or Town State Zin	Code)
Ĕ	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene 1 frem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		i i	5 Wayridge Drive,			
ore	of He		20a. Method of Disposition 20b. Place of Disp	osition (Name of matory or other place)	Date 2	20c. Location - City or	Town, State
Baltimore, Maryland 21215-0036	t. Pag tment rtant: ijury c					Brentwood,	Maryland
g	permit. Page 1 Department of I Important: If its any injury or of once.		21. Signature of Funeral Service Licensee M01463	2. Name and Address of Facility Si	mple Trib	ute	D 20052
			23a. Part 1. Piter the disease, or complications that caused the death. Do not en	1040 Rockvill ter the mode of dying, such as cardiac			Approximate
P	nysician/		shock of heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition	ral Vascular Acci	dent		Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	rai vasculai Meei	dent		
		Jer	Sequentially list conditions, b.  If any, leading to furnediate to the consequence of the				
1	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events				
)	ian an irial-tr	E	resulting in death) Last  Due to (or as a consequence of):				
2	physic the bu	edical	d				
200	oding I	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	han
POX	e atter	Physician/Me	in the past 12 months?  1 ☐ Yes 2 → No  1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
5	lt ure d	Phy	g Unknown  9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	and the same to be be Book!	- I		
γ.	signec	d by	Hypertension	underlying cause given in Part I.		acco use contribute to	the cause of death?
) Ta	peen	lete			24a. Was an		opsy findings available
Records,	te has	Completed			autopsy perform	prior to death?	completion of cause of
ה ה	rtifical		25. Was case referred to medical examiner?	26. Place of Death (Chec	1  Yes 2	P No 1 ☐ Yes	2 L No
Vitai	his ce	유	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing H	ome 5 🗆 Residen	ce 6 QOther (Speci	My Hospice
io i	h. After 1 funera	Certificate:	27. Manner of Death  1 Natural 5 Pending  28a. Date of injury (Month, Day, Year) injury	work?	28d. Describe how	injury occurred	•
DIVISION	r deat	ij	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Stre	et and Number or Rur	al Route Number.
	al Dire		building, etc. (Specify)		City or Town,		
i de di	within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation).	stigation, in my opinion, death occurred a	at the time, date and	place, and due to the o	ause(s) and manner stated.
4	vithin vithin on the comple		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and pla 29c. License number	ice, and due to the ca	ause(s) and manner as d. Date signed (Month	stated.
			Dince Kuld, ACRAP	R115108		pril 25, 2	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type,		1 11	<u> </u>	
			Diane Ruckert 6001 Muncaster Mill	Road Rockville,	MD 20855		
	Stat Registra	e r	31. Date filed (Month, Day, Year) APR 28 2010  2. Registrar's Signature	Ked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month May Physician/ Shirley Ann Creager Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick Frederick Heartfields Assisted Living 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth If Linder 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number av 25. 1931 Days Hours 1 □ M 2 🛛 F Months **Funeral** 78 218-24-9613 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medio I Examiner must be notified at within 72 hours after death with the Maryland Director 1 X Yes 2 No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Completed by Funeral 21701 7925 Longmeadow Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 21215-0036 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry
United States 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government and Mental Hygiene. is marked other than Supervisor 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) altimore, Maryland Grace V. Shearer of Health and Mental item 27 is marked ည Grayson F. Shull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7925 Longmeadow Drive, Frederick, Maryland 21701 David Creager / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) or other Date 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Smithsburg Crematory 5/11/2010 |Smithsburg, Maryland 4 Donation 5 Other (Specify) Keeney and Basiord PA Funeral Home, 21. Signature of Funeral Service Licensee 106 E. Church Street, Frederick, Maryland 21701 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. P. ft 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Ordset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown IF FEMALE: 23b. Was decedent pregnant Ectopic pregnancy Month Year in the past 12 months? 1 Yes 2 Unknown been signed by the sahould be detached t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? cate has page 2 s 2 🗌 No 1 Yes Yes 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical 8 B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 2 No မ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 1 Natural
2 Accid injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0035152 MO Drive Frederik MD 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnan

Registrar

U DHMH 17 Rev 7/2009

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J.L

31. Date filed (Month, Day,

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32. Registrar's Signature

Thus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2010 ear 11:33a Leona Baker Crout Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 613 Calliope Way Carroll Mt. Airy If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Ye Nov. 16. 1 □ M 2 🛣 F **Director** 76 1933 Maryland 218**-**28-8012 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 613 Calliope Way 21771 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🖾 No Maryland 21215-0036 1 Tes 2 X No Specify: 3 

Midowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Artisan <u>Folk Art</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ella M. Unknown George W. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn W. Riley/ Son Key Avenue, Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Memorial Park4/24/10 Hagerstown, Maryland. Stauffer Funeral 1621 Opossumtown . Signature of Fugeral Service Lice Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Olivo Ponto Cerebellar Degeneration disease or condition Medical Medical Examiner resulting in death) Due to (or as a consequence of) Progressive Cerebellar Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): respirator tow will Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal uea ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical the funeral director. 26. Place of Death (Check only one) Hospita Other: 2 🔀 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Naturai 5 Pending after death. Director: Af 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and tle of certifier April 27, 2010 D0059924 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Acol MD 1502 South Main Street, Mt. Airy, Maryland 21771 J. Chris 10 31. Date filed (Month 32. Registrar's Signature State Registrar

			Amend #17 & 18	ase Type or per Fh go State o	<b>Print in</b> 903 5/2 of Marylai	<b>Black II</b> 1/10 Thand 7 Department	ndelible In	<b>k. Ens</b> Health	and Ment	opies al Hygi	Are Legil	ble.	
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	Physicia Medic		MILDRED			CAME	BELL		Api		23, 201		A M
	Examir		4a. Facility Name (if not institution		nber)		4b. City, Town, o	r Location			4c. County of	Death derick	
	Funeral Director		Northampto 5. Social Security Number 231-56-2101	6. Sex 1 ☐ M 2 🛛 F	7. Age (In yrs. 69	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8. Da	ate of Birth fonth, Day,	1	9. Birthplace (State Country) Virginia	or Foreign
	faryland Ba-f show iified at	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Fre	derick	10c. Ci	ity, Town or Lo	cation Fredericl	c				10d. Inside C	ity Limits
	with the Ns 23a or 2 ust be no	Funeral Dir	10e. Street and Number 209 Thomas Av	e.			10f. Zip Code 2170]	L		10	Og. Citizen of Wh		
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 🔀 Mar  3 ☐ Widowed 4 ☐ Divorced	ried Armed Fo	<sub>e</sub> 2X□ No	1	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🟋 No	n, Mexicar	n, Puerto Rican,	es or No- etc.)		American Indian, White, etc. White	
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and 2	be filed wi ental Hygik ked other ic event, t	a)	17. Father's Name (First, Middle, L		e Will:			18. Mothe	er's Name <i>(First,</i>				
Baltimore, Maryland 21215-0036	and 2 should be file Health and Mental I tem 27 is marked of ther traumatic eve		19a. Informant's Name/Relationsl Richard Campbel		Husband		g Address (Street a			e Number, C	City or Town, Stat		
timore	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition  1	Specify)	State	cemetery, cren	sition (Name of natory or other place fort Cem		Date 4/30/20			ity or Town, State	inia
Ball	permit Depart Impor any in		21. Signature of Funeral Service L	Otal	More	1		sumto	wn Pike	, Fred		Home MD 21702	
	h sician/ Medical		23a. Part 1. Enter the disease, or snock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_ a M.		estic	Adeno (				t,	Approximat Interval Bet Onset and	ween Death
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Box 68760	ne death certificate be y the attending physici tched for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown		Birth 2 ☐ Feta nantat time of o	al death 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of Month		Year
ds, P.O.	s the	þ	Part II. Other significant conditio	ns contributing to de	eath but not res	sulting in the ur	nderlying cause giv	en in Part I	. 23			te to the cause of d	
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ta .	rnysician: I this certifica ral director, p	ďΙ	25. Was case referred to medical examiner?	Hospital:			Otho		h (Check only o	ne)			
<u>`</u>	rthis ral dir	유	1 ☐ Yes 2 No  27. Manner of Death	1 □ 1 28a. Date o	Inpatient 2  of injury	ER/Outpatient 28b. Time of	3 DOA Other	4 X Nu			ce 6 Other (S	Specify)	
Sion	death. ctor; Afte y the fune	Certificate:	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	g (Monta	h, Day, Year)	injury	work?		No		injury occurred		
DIV	Spiral or of the cours after seral Direction of the course	- 1	4 ☐ Homicide determi  29a. Certifier 1 【Certifying		ig, etc. (Specify	)		date and n	Cit	y or Town, S	State)	r Rural Route Numb	er,
44	thin 24 the function of the fu	Med	only one) 3 Contitying	xaminer: On the basi Nurse Practioner: T	s of examination	n and/or investi	gation, in my opinio	n, death occ	curred at the time	e, date and p	place, and due to	the cause(s) and ma	nner stated.
	. ½ <b>℃</b> 8		29b. Signature and title of certifier				D4	3091		290	d. Date signed (M 4 - 23 - 2	lonth, Day, Year)	
	2		30. Name and address of person w	di MO		23a) (Type, Pr <b>80</b> /	TOLL by	tem	c Ave	, 6	redonc	er as stated.  Ionth, Day, Year)  2010	21701
	State Registra	9	31. Date filed (Month, Day, Year)	32. Re 2 9 2010 ▶	gistrar's Signat	ture	Sake						

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			1 - For State Registrer	State of Ma	rylan				ealth a Death			Reg. No.	nin	15	174
	Physici /Medio	_	1. Decedent's Name (First, Middle, La	s eorg &	· c	000,					Date of De Month	Day 2	201	04:	of Death
	Examir Funeral Director	i. L	5. Social Security Number 6.	DORF		last birthday)	A	r 1 Year	If Under 2 Hours	BN	Date of Bir (Month, Da Feb. 2	(	SAX 9. Bin 914 Ma		_
	e Maryland	Director	Usual Residence of Decedent	t		y, Town or Loc lenry	cation								City Limits
136	be filed within 72 hours after deeth with the Maryland ital Hygiene.  Id other than "natural", or items 23a or 28e-f show event, the Medical Exeminal most be notified at	by Funeral Dire	10e. Street and Number  1367 Friendsville  11. Marital Status  1 Never Married 2 Married  3 🖫 Widowed 4 Divorced	2 Rd.  12. Was Decedent E Amed Forces?  1  Yes 2 N If Yes, Give Year or Dates:		If	Vas Dec Yes, sp	D Code  1541  Ident of Hiscify Cuba  2 No	spanic Orig n, Mexican, Specify:	in? (Speci Puerto Ri	ify Yes or No can, etc.)	USA	14. Race - Ame Black, Whit	encan Indian,	,
121	e filed within 72 hou al Hygiene. other than "nature vent, ine Medice E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	+)	16a. Deced (Give) life. L	kind of w OO NOT	ork done d use retired	luring most )	of working	7		nd of Business		
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	1 and 2 Health a em 27 la		19a. Informant's Name/Relationship Arthur G. Codding 20a. Method of Disposition	gton, Jr./S	20b. P		Frie	ndsvi	lle F		P.O. B	ox 2	19, McF	Henry,	MD
Baltimore,	permit. Pages Department of I Important: If it any injury or o once.		1 🔀 Burial 2 □ Cremation 3 ( 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	(fy)		ooming 22	Rose Name a	e Cem	etery	New		nera	riendsv 1 Homes 21530	, P.A.	
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	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions			1	derlying 4	cause give	en in Part I.			tobacco u	use contribute t		of death? Unknown
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Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manne of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not	28a. Date of Injur (Month, Day	v	ER/Outpatient 28b. Time of Injury	3 🗆 E	28c. Injun Worl	er: 4 □ Nur	sing Home	Check only of Sesi	dence	6 Other (Spery occurred	ecify) A35	15751 ARS
DIVE	e Hospitel or Att 24 hours after de Funerel Direct letely filled in by t		4 Homicide determined	building, etc	(Specify	y) wledge, death	occurre	at the tim	ne, date and	d place, an	City or To	wn, State	) and manner a	s stated.	
)	To the Hor within 24 h To the Fur completely	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier  Paul Dan	and manner sta	examina ted.	ition and/or inv	estigation 2	n, in my op lc. License	oinion, deat	h occurred	at the time,	date and	te signed (Mon	e to the caus	r)
1	Sta Registi		30. Name and address of person who Pau I Panie 31. Date filed (Month, Day, Year)	completed cause of de	eath (Item 6 h's Signa			A C B	205	DRII	150	Alc	-03	, M	7

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day RICHARD KENNETH DAVIS 2010 May 10 3:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caraway Manor Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Days 1 🙀 M 2 🗆 F 206-12-1263 Director Fe<u>b</u> 85 1925 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Elkton 1 Yes 2 XNo MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40 Canal Drive 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, 1 ☐ Never Married 2 🙀 Married Yes 2 No þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. WWII other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Electronic Powders 4 Engineer Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked out any injury or other terms 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Davis Elizabeth Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Davis (wife) 40 Canal Drive Elkton, MD. 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) st. Stephen's Cem. 5/17/10 Earleville, MD. Signature of Propried Environ Lin 22. Name and Address of Facility Galena Funeral Home of Stephen L Schaech M00510 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final disease or contion resulting in death) Onset and Death Physician/ Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Certificate: To I 2 🗹 No 6X Other (Specify) Assisted 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tite of certifier 5.11.2010. achder-S. MD D0023322

State Registrar DHMH 17 Rev 7/2009

DIC

31. Date filed (Month)

126 A, E.

tagh ST, Eleten MD21921.

person who completed cause of death (Item 23a) (Type, Print)

Amended Item 18 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  No.											
Physici /Medic											
Examir		4a. Facility Name (If			ımber)			, or Location of Dea	ath	4c. County of De	
Funeral		St. Vince 5. Social Security No		e Center	7. Age (In yrs.	last birthday)	If Under 1 Ye			Freder	irthplace (State or Fore
Director		219-01-16	41	1 ☐ M 2 🛣 F	89	Yrs.	Months Day	/s Hours Mi		ay, Year) ( 1, 1920 Mar	Country)
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or 28a e noti	Funeral Director	10e. Street and Nun					10f. Zip Cod	е		10g. Citizen of What C	Country?
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h and Mental Hygie 7 Is marked other ti raumatic event, th	To Be C	17. Father's Name ( John B						18. Mother's N Anne	Hopper D	oyle Smith	<b>-</b>
ls ma		19a. Informant's Na	_				,			ber, City or Town, State	
Health em 27 ther to		Cora Anne 20a. Method of Disp		igo se	ervant 206. F	Place of Disno	neition (Name of		Date	urg, MD 217	
Department of Health a Important: If item 27 Is any Injury or other tra		1 Burial 2 ☐ 4 Donation	☐Cremation 5 ☐ Other (S		State St	· Tose ovinci	ph <sup>ry</sup> s <sup>rother</sup> al House	5/3	/2010	Emmitsbur	g, MD
Depar Impor any In		21. Signature of Fu	neral Service	1	La roma		2. Name and Ad 210 W Ma		Myers-Du mmitsbur	rboraw Fune g, MD 21727	eral Home
ojan and Medical kaminer	Examiner	Immediate Cause (disease or condition resulting in death)  Sequentially list contrary lands in the cause. Enter Under Cause (Disease or that initiated events resulting in death) L	Final  Inditions, Inditions Inditions	ab	(or as a conseq	uence of): uence of):	ya S	trohe			Initiaryal Between Onset and Death 2 1 h a
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24 hours after death. <b>e Funeral Director:</b> Aft letely filled in by the fun		29a. Certifier (Check only one)		Examiner: On the	basis of examina nn <b>e</b> r stated.	alion and/or ii	ivestigation, in i				
within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical Certi	(Check only	Medical	Examiner: On the and ma		allu		D1870	25	29d. Date signed (Mo	onth, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Mabel Y. Davis April 30 2010 6:02 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Look About Manor Assisted Living Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 X F 215-20-9426 Director 89 June 2, 1920 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the "Motical Examiner must be positived at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Halter Rd. Funeral 21158 TISA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ģ 1 ☐ Yes 2 TNo Specify: Specify: White 3 ₩idowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within 7 of Health and Mental Hygiene. Item 27 is marked other than "n other traumatic event, the Media College (1-4or 5+) Elementary/Secondary (0-12) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jason Bradley Yelton Stella Hill ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If Item 27 or other t Roy Davis/Son 1416 Stone Rd., Westminster, MD 21158 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 New Marichester 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 05/03/2010 Manchester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lutheran Cemeterv 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final end **Physician** ement disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Day Year 5 Other (specify) the 9 Unknown been signed by Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 2 No 2 400 1 □Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? DOMERTA 1 Yes 2 No Other: 4 Nursing Home 5 Residence Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 6 ☑ Other (Specify) Cwc 28a. Date of Injury (Month, Day, Year) funeral 27. Manne of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check o one) 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 30 2010 12 30. Name and ad ss of person who completed cause of death (Item 23a) (Type, Print) Philip Ruzbarsky MD 125 Airport Dr. Westminster, MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore.

Division of Vital Records, P.O. Box 68760,

S. Jak **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ APR 24, Mildred Emily Donaldson 2010 11:32 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 10421 Windsor View Drive Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 😾 F Months Days Hours Min Month, Day, 218-20-0699 83 Director Mary Land Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10421 Windsor View Drive 20854 United States 11 Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: Caucasian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Ith and Mental Hygie 27 is marked other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be fil Health and Mental Item 27 is marked ပ္ Alden Thomas Keeting Edna Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 2 William A. Donaldson / son 10421 Windsor View Drive, Potomac, MD 20854 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Atlantic Crematory 04/27/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Thibadeau Mortuary Service, p.a.
7 Park Avenue Coitheanth Signature of Funeral Service Licensee M00956 Park Avenue, Gaithersburg, MD 20877 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death MONTHS Ph<sub>sician</sub>/ a. ARRHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, Examiner trany heating to Immedia cause. Enter Underlying Cause (Disease or iinjury Duirtu (or es e consequence of, or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a betached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CANCER OF LUNG. 1 Kes 2 No 3 Probably 4 Unknown Completed HYPERTENSION . Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 A No s after death.

Director: After this certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 XNo Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled hours Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I only one 29b. Signa 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

address of person who completed cause of death (Item 23a) (Type, Print)

1201

Registrar's Signature

M.D.

28 2010

FRAUKE WESTPHAL,

31. Date filed (Month, Day, Year)

D10493

SEVEN LOCKS ROAD, ROCKVILLE, MD 20854

APRIL 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ava Virginia Evans 2010 2:35  $\mathbf{A}^{\mathsf{M}}$ May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Hours 1 ☐ M 2 💢 F **Director** 525-56-6210 03/01/1931 New Mexico Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be neelfied at Director 1 XYes 2 No Loch Lynn MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21550 United States 421 Roanoke Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. LPN Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Conrad မ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) D partment of Health an In portant: If item 27 is any injury or other traugores. Rev. Arthur J. Evans, Husband 421 Roanoke Ave, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 05/0672010 N Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD 23a. Part 1. Enter the disease, or complications to accused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque e of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Certification: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy 2 ENO 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation heral Director: A filled in by the fu 1 ☐Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier Learning Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 To the I 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LITA 255 5 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Leonard Ehrlich 24 2010 Medical <u>April</u> 0:50 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15300 Beaver Brooke Court #2D Silver Spring Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min 1 X M 2 - F Country) Washington. Director 82 Yrs 577-32-8583 DC Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 15300 Beaver Brooke Court #2D 20906 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3€ Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Management Specialist US Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I မ Page 1 and 2 should be Saul Ehrlich Anne Moerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a other t Mona Ehrlich, daughter 5705 Harpers Farm Road, #E, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important; If ite any injury or of once, 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Domation 5 Other (Specify) Judean Memorial Gdns | 04/27/2010 Olney, Maryland . Signature of rise Licensee Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852 MO1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 10 months Metastatiz High-Grade Invasive Bladder Carcinoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading long and late cause. Enter Underlying Cause (Disease or iinjury Examiner Events for as a nonsequence of that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bannen, MD,

28 2010

Paul A.

31. Date filed (Month, Day, Year)

MD060335

9715 Medical Center Dr, Suite 221, Rockville, MD

April 26, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 25, Day 2010 Year Ekene Ejedoghaobi 9:55 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan. 24, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year 1980 30 Months Days Hours Min. 1**X** M 2 □ F Nigeria 214-41-2761 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2908 Collins Avenue Funeral 20902 IISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TxNo Specify ģ Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank O. Ejedoghaobi Juliana N. Mmegwa ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank O. Ejedoghaobi/Father 2908 Collins Avenue, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State May 8 2010 Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 20901 23a. Part 1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications of Sickle Cell Disease years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 st autopsy perform 2 🔼 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2X ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: d in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D43539 April 25, 2010 30. Name and codies of person who completed cause of death (Item 23a) (Type, Print)
Raymond White, MD 1500 Forest Glen Road, Silver Spring, MD 20910

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

28 201

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		Marylan	-	artmen tificate			and M	1ental Hy	gien Reg. N	201	0	15182
	Physicia Medic		1. Decedent's Name (First, Middle,	<u> </u>		FRE	EGA	PAN	JE		2. Date of De Month APRIL		, 20°1	ar O	3. Time of Death
	Examin		4a. Facility Name (if not institution, g	GENERA	L ItOS			OLN					C. County of E		MERY
	Funeral Director		213-66-4456	i. Sex 1 ☐ M 2 ☐ ★F	7. Age (In yrs. Ia 75	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir July 2	th Year)	1934 g.	Birthpla Country	ce (State or Foreign  1) Italy
	Maryland 28a-f show etified at	Director	Usual Residence of Decedent	Montgomer		y, Town or Loc	cation							100	d. Inside City Limits
	with the s 23a or 2	Funeral Di	10e. Street and Number 16912 MacDuff	Avenue			10f. Zip	Code 832				_	itizen of What	t Countr	y?
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  13 Never Married 2  Marrie 3  Widowed 4  Divorced	12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Date	es? 2 🔀 No	Н	Vas Decede Yes, speci			gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V Specify: V	/hite, et	C.
21215-(	vithin 72 ho jiene. er than "nat the Medica	Completed	15. Decedent (Specify only highest Elementary/Seconday (0-12)		or 5+)		lent's Usua kind of work DNOT use	k done du retired)	tion uring most	of worki	ing	16b.	Kind of Busine Textil		stry
Maryland 21215-0036	should be filed within 72 hours after c and Mental Hygiene. is marked other than "natural", or 'aumatic event, the Medical Examin	To Be	17. Father's Name (First, Middle, La: Stefano Fregap						18. Mothe		e (First, Middle, gusa	Maider			
	and 2 shou Health and tem 27 is rr other traum		19a. Informant's Name/Relationship Pietro Fregapan								nue, Ol				de)
Baltimore,	Page 1 a ment of H ant: If ite ury or ott		20a. Method of Disposition  1    Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Sp		State C	Place of Disposemetery, crem Ce of H	natory or ot	her place			<sup>fate</sup> 2010		Location - City		<sub>n, State</sub> g, Marylan
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lic	ensee Oæle	٠	22 F <u>1</u>	Name and	Address	of Facility Coll rsity	ins Blv	Funera	l Ho	me Inc	rin	g, MD 2090
	Physician /  Medical Examiner prize	dical Examiner	shock, or heart failure. List only one cause on each line.											Approximate neterial Between of the proximate of the prox	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The certificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	₩.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		irth 2 🗍 Feta ant at time of c	ldeath 3 🗌	] Ectopic p ] Other (spe		′				23d. Date of Month		y Day Year
ds, P.O.	luires that t an signed b uld be deta	ρ	Part II. Other significant condition PARKINSONS			ulting in the u	nderlying c	ause give	en in Part I	*					cause of death?
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed	BREAST C	ANCER							24a. Was auto perfo		prior	to com h?	y findings available pletion of cause of
ital	ician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:				Othor	ce of Deat						
n of V	ding Phys h. After this funeral di	sate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month)	npatient 2 finjury , Day, Year)	28b. Time of injury		Bc. Injury work?	_4 ⊔ Nu at	- 1	me 5 Residence Reside Page 1			pecify)	
Divisio	tal or Atten rs after deal al Director: ed in by the	l Certificate:	2  Accident Investiga 3  Suicide 6  Could no 4  Homicide determin	ot be 28e. Place o	f Injury - At ho g, etc. (Specify	me, farm, stre )			2		28f. Location (\$ City or Tov			Rural F	Poute Number,
	he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2 L Medical Exa	hysician: To the beaminer: On the basis lurse Practioner: To	of examination	and/or investi	igation, in m	ny opinior	n, death oc	curred at	the time, date a	and plac	e, and due to	the caus	e(s) and manner stated.
	P with		29b. Signature and title of certifier	Deur			1		418			APA	ate signed ( <i>M</i>	7, 3	2010
			30. Name and address of person who DLUYEMISI	no completed cause	of death (Item	23a) (Type, P	rint) 181	DIPE	ZINCI	E PH	HUP DE	201	LNEY,	MD	20832 SPITAL
	Stat Registra	te	31. Date filed (Month, Day, Year)		gistrar's Signat	ure back	1.0	IVLUI	0146	int	ing un	-145		(10)	J. (1/\_

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ JOHN, FERGUSON 2010 1150 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL N/A CENTER BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. May 21 pay, Days Hours Missouri 499-36-1237 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 20 any injuy or other traumatic event, the Madianal once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director tx Yes 2 ☐ No MDPrince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 904 Chillum Manor Court 20783 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Elementary/Seconday (0-12) College/(1-4 or 5+) Research Scientist Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Ferguson Fredna Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Chillum Manor Court, Hyattsville, MD 20783 Doretha C. Ferguson -wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other particular Memorial 4/28/10 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linnse 22. Name and Address of Facility McGuire Funeral Service Inc. 7400 Georgia Avenue, N.W. Wash., D.C. 20012 Goanna & Cliberry 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) signed by the attending physician and de detached for use as the burial-transit executed Cause (Disease or liniur) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown HTN been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 s autonsy death? 1 🗆 Yes 2 🗖 1 ☐ Yes 2 ☑ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,

State Registrar

To the Hospital within 24 hours a To the Funeral D

Medical

29a. Certifier

(Check only one)

29b. Signature and

park

Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number P24385 City or Town, State)

04/21/2010

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

ANDREA HUMMY

31. Date filed (Month, Day, Year)

building, etc. (Specify)

11 S. EUTAW ST.

rund

Registrar's Signat

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29, 2010 Month April Alexander Turner Frost 5:19 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Goodwill Mennonite Home Grantsville Garrett 8. Date of Birth (Month, Day, Year April 1, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Year) Hours Min. Days 1 X M 2 □ F Months 1932 Alabama 232-48-4004 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Friendsville MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21531 702 Morris Ave., Apt. 103 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16b. Kind of Business/Industry Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hollis Frost Lorine Beaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5710 Trailview Ct., Apt. A-12, Frederick, MD 21703 Debra L. Heinzmann/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 30, 2010 Apr 4 ☐ Donation 5 ☐ Other (Specify) Country Side Crematorv Davidsville, PA 21. Signature of Funeral Service 22. Name and Address of Facility Newman Funeral Homes, P.A. - Lyce leso P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acr disease or condition resulting in death) Due to (or as arconsequence of): Cerebralvasa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): na ue to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 26. Place of Death (Check only on

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P.O. Box 68760,

Division of Vital Records,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Examiner must be notified at

death \

and 2 should be filed within 72 hours after

al Hygiene.

h and Mental F is marked of

permit. Pages 1 and 2
Department of Health ar,
Important: If frem 27 is m,
any injury or other 2

altimore, Maryland 21215-0036

Examine Physician/Medical δ Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of ath

Natural Accident

3 Suicide

4 ☐ Homicide

Hospital: 5 Pending investigation

6 ☐ Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) friging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ary

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death /O<sup>Year</sup> Month Dav **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown 14014 mish oile Maryland Washing Magaziona If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X F 204 26 9486 Director Sept.03,1931 DE Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County or items 23a or 28a-f show aminer must be notified at 1 ☐ Yes 2X No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 17731 Mason Dixon Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 XWidowed 4 ☐ Divorced White "natural" Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Washington County Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 6 School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fil.
Department of Health and Mental Himportant; If Item 27 Is marked oth any Injury or other traumatic event Gladys Schetrompf Jabez Knable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1188 Leisure Drive Chambersburg, PA 17202 Michael K.Garland, Sr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 05/10/2010 Warfordsburg, PA Plesant Grove Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street MUOZGO Grove Funeral Home, P.A. Hancock, MD 21750-0368 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit and Due to (or as a consequence of): physician a Box 68760. Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1□ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi. within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) sompletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, May 05, 2010 80. Name and address of person who completed cause of death (Item 23a), (Type, Print) Marsh Pille Hagerslown olephanie CRNP Concordia pmer-32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

10-03477 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Julie Ann Gibbons 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ May 5, 2010 Julie Ann Gibbons 0859 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3567 Cemetery Lane Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Country Maryland Months Days Hours Director 46 1964 Feb 23, 213-94-1784 1 M 2 F Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location s 23a or 28a-f show e notified at once. 1 Yes 2 No Maryland Carroll Westminster mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Heaith and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f she ury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3567 Cemetery Lane 21158 Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes white 1 Yes 2 No specify: 3 Widowed 4 Divorced f Yes, Give Year Specify þ 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 18 Mother's Name (First\_Middle\_Maiden Surname) 17. Father's Name (First, Middle, Last) James Ward Mae Wheeler 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Sean L. MacDermott, fiance 3567 Cemetery Lane, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/10/2010 Morehead Memorial Union Mills, MD Donation 5 Other Specify 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Combined drug (oxycodone & fentanyl) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to or as a consequence of Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED 23a,27,28a-f,perME G904 6/7/10 TT X UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of deliver 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' r this certificate h ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 27, Manner of Death Certification: 1 Natural 1 Yes 2 No unk 5 Pending 24 hours after death. the Funeral Director: npletely filled in by the Fd 5/5/10 Fd 8:43 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5567 Cemetery Lane Westminster, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the WIL 0

Medical

30. Name and address of person who completed cause of eath (Item 23a) Theodore M. King, Jr., MD. 31. Date filed (Mopth, C State

29b. Signature and title of certifier

Assistant Medical Examiner 32. Registrar's Signature

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 6, 2010

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Mary					Mental Hy	giene	9	1.0	15107
		-	Registrar  1. Decedent's Name (First, Middle, Last)			Cen	tificate of D	<i>eath</i>	2. Date of De	Reg. N	0		0 18 /
	Physicia		Marlene Linda	Gay					Month April	27	ay 2C	Year	3. Time of Death  12:42P M
***	Medic Examin		4a. Facility Name (if not institution, give sa				4b. City, Town, or	Location of Death			c. County of		1 12:425
لمرر			643 Washington	Ave.			Hagers	town			Washi		on
	Funeral		Social Security Number     6. Sex     1	7. Age (In	yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)		9. Birthp	lace (State or Foreign
	Director		219-54-0934 Usual Residence of Decedent	6	2 Y	rs.			Aug. 3	0, 1	947 M	Count [ary]	and
	and show lat	or	10a. State 10b. County	100	c. City, Town	or Loc	ation					10	Od. Inside City Limits
	Maryl 28a-f etifiec	rect	Maryland Washingto	$_{ m on}$	Hagers	tow	m.						1 XYes 2 □ No
	aor;	al Di	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zip Code			10g. C	itizen of Wh	at Count	try?
	th wit ns 23 must	Funeral Director		lve.		_	21740				S.A.		
	r deal	by Fu	11. Marital Status  1  Never Married 2  Married	2. Was Decedent Ever i Armed Forces? 1 Yes 2 No	in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black,	America White, e	
Š	safte ral", d Exan	q pe	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 XNo	Specify:			Specify:	Whi	te
ဂ ဂ	"natu dical	Completed	15. Decedent's Edu (Specify only highest grad	cation			ent's Usual Occupa ind of work done de		dna	16b. l	Kind of Busi		
7	hin 72 ne. <b>than</b> ie Me	mo:	Elementary/Seconday (0-12)	College (1-4 or 5+)	-	ife. DO	NOT use retired)		ang				
N	ed wit Hygie other	Be C	17. Father's Name (First, Middle, Last)				Cafe	teria 18. Mother's Nam	o (Eirot Middle			Gov	vernment
j a	be file ental ked c	인	Lewis Wiles					Pauline			Surname)		
Maryland 21215-0036	nould Ind Mi s mar umati		19a. Informant's Name/Relationship (Type	e, <i>Print</i> )	19b.	Mailing	g Address (Street a				r Town, Sta	te, Zip C	ode)
Σ	d 2 sl alth a 27 ii ertra		Clorissa K. Wilder	/ Daughter	10.00		Mashingto						
or o	of He of He if item ir oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	21	0b. Place of i	Dispos	ition (Name of atory or other place		Date		ocation - C		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important if frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)		-	ave	n Cemete:	ry 4/30	/2010	Hag	ersto	wn M	lary1and
gail	Departiment of the properties		21. Signature of Funeral Service License				Name and Address						
_	462 00		23a. Part 1. Enter the disease, or compli	$\mathcal{P}$	dooth Done						stown	- 1	land 21742
			shock, or heart failure. List only one immediate Cause (Final	cause on each line.						1651,		- 1	Approximate Interval Between On et and Death
	nysician/ Medical		disease or condition resulting in death)	Due to (or as a con	(ALO)	90	TERY S	FRC7 10	4			- 1	Houn
	Examiner			CORDIAN	by )	472	TERY 3	DIPLACE					
	_	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of	):		7 7				$\neg$	
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	e exercian a	alE	resulting in death) Last	Due to (or as a con	sequence of	):							
3	cate be executed physician and transit the burial-transit	edical	d										
8	nding se as		IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcome of pr	egnancy						23d. Date	of delive	n/
XOY T	eath o	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at time			Ectopic pregnancy Other (specify)	/			Montl		Day Year
. ·	by the tache	hys.	9 🗌 Unknown	9 Unknown					1				
J	gned be de		Part II. Other significant conditions con	tributing to death but no	ot resulting in	the un	derlying cause give	en in Part I.					e cause of death?
cas	een si	sted	The soul i	Ne sijek	1/0	<i>)   1</i> 3(	30 1el		1 🗆	Yes 2			ably 4 🗹 Unknown
Vital Records,	has by	Completed by	Mypishite from	JP & Rep	Keirl	$\nu$	m/Culm	91184/	24a. Was autor	osy	pri	or to con	sy findings available apletion of cause of
ב ב	icate r, pag		BUNDALGT					J	1 🗆 Yes	rmed? 2 N		ath?	2 □ No
Ta	certif	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	- 5/		Other	ce of Death (Chec					
	eral d	e: To	27. Manner of Death	1 ☐ Inpatient :	28b. Tir	me of	3 L DOA 28c. Injury	4 □ Nursing Ho at	ome 5 L Resid 28d. Describe h			(Specify)	
uo	ath. r: Afte	icat	1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Yea	ar) inj	ury	M 1 □ Y	res 2 🗌 No		•			
DIVISION OF	ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp		n, stree	et, factory, office		28f. Location (S			or Rural F	Route Number,
בֿ <u>រ</u>	urs af	alc		la constant				-					
200	four enough an attending Priysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check 2 L Medical Examine	ian: To the best of my ker: On the basis of examin	nation and/or	investig	gation, in my opinior	n, death occurred a	t the time, date a	and place	e, and due to	the caus	se(s) and manner stated.
4	vithin To the	Σ	only one) 3 L Certifying Nurse  29b. Signature and title of certifier	Practioner: To the best	of thy knowled	age, ae	29c. License				s) and mannate signed (/		
	0		· le le lo 24	)—			2-21	2313			L	1-2	9-10
	.		30. Name and address of person who cor	· ·			int)						
51	4-0		Eli J. Roza, MD	12931 Oak		Av	e., Hageı	cstown, N	4D 217	742			
	Stat Registra	e	31. Date filed (Month, Day, Year) A Y 3 20	32. Registrar's S	ignature	1	- 4.1						
	- 10913616			Johnson		4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 1, 11:05 AM 2010 Lena Anna Elizabeth Glotfelty /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Frostburg Village Nursing Home Frostburg If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** July 4, 1915 New Jersey Director 212-38-6548 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director Accident Garrett 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in the Health and Mental Hygiene. An entit of Health and Mental Hygiene. Then "natural", or items 23a or is marked other than "natural", or items 23a or in any or other traumatic event, the Manical Examine may be any or other traumatic event, the Manical Examine may be any or other traumatic event, the Manical Examine may be any or other traumatic event, the Manical Examine. USA 21520 101 Town View Dr., Apt. 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3K Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Garrett County Board Elementary/Secondary (0-12) College (1-4or 5+) of Education Cafeteria Worker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Viola Smith မ George Helfrich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 Freedom Circle, Winchester, VA Barbara J. Wolff/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. May 5, 2010 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery Accident, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WROMAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 🔁 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 ☐ Yes 2 XXX 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

State

Registrar

Hedler

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

29b. Signature and title of certifier

Harjit S.

Sidhu, 925 Bishop Walsh Rd., Cumberland, MD

29c. License number

126907

21502

29d. Date signed (Month, Day, Year)

2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Oldio of Mic	•	Certificate o				Reg. No. 2	0 15189
	Physicia /Medic		1. Decedent's Name (First, Middle, La Waymond	<sub>ast)</sub> Goodson					2. Date of Dea	ath 26, <sup>Day</sup> 2010 <sup>Yea</sup>	3. Time of Death 4:55 p M
Andrew .	Examin		4a. Facility Name (If not institution, gi Holy Cross Hosp		-	4b. City, Town	, or Location r Spri			4c. County of De	
7	Funeral Director			Sex 7. Age № M 2 F 8	o (In yrs. last birth O Yı	Months   Day		Min.	8. Date of Birt (Month, Da July	y, Year)	irthplace (State or Foreign Country) • C •
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	e Mar 8a-f st	Director	****	tgomery	S	ilver Spr					1 ☐ Yes 2 <b>X</b> No
	with the		10e. Street and Number 12600 Arbor Vie	w Court		10f. Zip Cod	e 0902			10g. Citizen of What G	Country?
	r death	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify C		rigin? (Spe	ecify Yes or No- Rican, etc.)		nerican Indian, nite, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Madical Examinar must be redified at	by	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 <b>X</b> Yes 2  N If Yes, Give Year or Dates:	1954-56	1 □ Yes 2 ☐				Specify:	Black
15-(	in 72 h "natu	Completed	15. Decedent's E (Specify only highest gi	ade completed)		ecedent's Usual Oc Give kind of work do ife. DO NOT use ret	ne durina mo	st of workin	ng	16b. Kind of Busines	ss/Industry
212	d with	Com	Elementary/Secondary (0-12)	College (1-4or 5	+)	Health I					usiness
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Extrainer mast be reciffed at once.	To Be (	17. Father's Name (First, Middle, Las Marion Goodson	t)				ner's Name ona H		Maiden Surname)	
<b>lary</b>	2 shou and N is ma	g J	19a. Informant's Name/Relationship	, ,	1					er, City or Town, State	
re, l	s 1 and 2 and 4 has the a litem 27 is		Betty Goodson/Wi 20a. Method of Disposition	fe	20b. Place of D	Disposition (Name of	1		ate	r Spring,  20c. Location - City	
timo	t. Pages tment or tant: If i		1 Magurial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec	ify)		crematory or other perans Cem	etery		10	Crownsvil	le, MD
Ba	Depar Impor any ir		21. Signature of Funeral Service Lice	nsee		22. Name and Ad Francis 500 Univ	dress of Facil J. Col ersity	lins Blvd	Funera	l Home Inc Silver Spr	ing, MD 20901
i			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	one cause on each lir	dying, such a	s cardiac o	or respiratory a	rrest,	Approximate Interval Between Onset and Death		
ing	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASC	a consequence of						
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	ted rsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of	):					
0	rtificate be executed ng physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence of	):					
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Вох б		ın/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	3 ☐ Ectopic pregna	ancu			23d. Date of	,
P.O. B	The law requires that the death oe atendi ate has been signed by the attendi page 2 should be detached for use	Physician/I	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		5 Other (specify				Month	Day Year
	uires that the de signed by the a d be detached f	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in t	he underlying cause	given in Part	1.			to the cause of death?
corc	w requir been s should	leted							24a. Was		Probably 4 nknown autopsy findings available
Division of Vital Records,	<b>hysician:</b> The lav his certificate has I director, page 2.9	Completed							autor perfo		to completion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Other:		(Check only o		
J of	ding Phys h. After this funeral di	n:To	27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 ER/Outp ry 28b. Tin v Year) Ini	atient 3 1 DOA	4 L ∖ njury at Vork?			dence 6 ☐ Other (S how injury occurred	pecify)
sior	ttendin death. tor: Af the fur	catic	1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not	on .		M	□Yes 2□		OOL Logation (	04	Burnt Bouts Alumbay
<u>N</u>	al or Attend s after death al Director: A	Certification:	4 Homicide determined	building, etc	c. (Specify)	n, street, factory, offic	se		City or Tov	Street and Number or vn, State)	nural noute (variber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director.	Medical (		hysician: To the best of miner: On the basis of and manner sta	f examination and						
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta		29c. Lic	ense number			29d. Date signed (Mo	onth, Day, Year)
	7+1		Jen G	1/1		Ď	2436	18	7.0	4.	26.2010
	1 1		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print) 1500 Fore	1+G1	en R	ad Si	Iver Sor	26.20/0 ing.MD 20910
İ	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	all of					- J

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:35amGreenspan 2010 Stanley Ira Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Y June 01 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 1 🗶 M 2 🗆 F 68 **Director** 052-32-4269 New York Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director Bethesda 1 Yes 2 1 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral U.S.A. 20814 7201 Glenbrook Road items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 2 □ No 1967ò Completed by 1 Never Married 2 X Married X Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes, Give Specify: "natural", 3 Divorced 1970 Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Medical Physician 5+ Be permit. Page 1 and 2 should be filed of Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean Jackier Philip Greenspan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Spouse 7201 Glenbrook Road. Bethesda. Maryland 20814 Nancy Thorndike Greenspan Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 05/04/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Sign ture of Funer I Service Licer W 11800 New Hampshire Ave., Silver Spring, MD 20904 M0124 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the tuneral director, page 2 should be detached for use as the burial-transit Sepsis Cause (Disease or iinjury that initiated events Due to (or as a consequence of) 3 resulting in death) Last Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DD\$6816\$ 4/27/10 30. Name and address of person who completed sease of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20851 Kimberly Zuzak.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 30

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 26. 2010 Gladys Moselle Hall /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 2525 Baltimore Blvd., Lot #16 Finksburg Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F Director 68 March 9 1942 Maryland 215-40-1399 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland Carroll Finksburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2525 Baltimore Blvd., Lot #16 21048 USA Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CNA & Medicine Aide is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumattc event once. Anita Whirley Howard Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Baltimore Blvd., Lot #16, Finksburg, MD 21048 Jesse M. Hall, Jr./Husband 20b. Place of Disposition (Name of Carrison Forest 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/06/2010 4 □ Donation 5 □ Other (Specify) Garrison, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Addréss of Facility Pritts Funeral Home and Chapel, P.A. Markel 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Eta: the disease, or conclination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ardiomy spal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 1 ☐Yes 2 ☐No 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7:45

10d. Inside City Limits

Onset and Death

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Westminster MD

29d. Date signed (Month, Day, Year)

POVS

Year

White

1 ☐ Yes 2X No

To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu WIL

> State Registrar

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4 Homicide

(Check only one)

29a. Certifier

DHMH 17 Rev 1/2001

🖆 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 26 Day 2010 Year Rosa Lee Hickey 11:01a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min Dec. 25 Director 85 1924 Georgia 467-52-4871 Usual Residence of Decedent or 28a-f show e notified at 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince George's Lanham 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 20706 9503 Tuckerman Street IISA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Caregiving Caregiver marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Bryant Walter Sanford permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9818 Woodberry Street, Lanham, MD 20706 Emily Hickey/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 200. Mace of Disposition (National Cemetery, crematory or other place)
Arlington National Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State May 120 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee Francis Adjess Coullyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death

days Physician/ Rheumatoid Arthritis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 XNo Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hemolytic Anemia, Respiratory Failure, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Kidney Failure, Interstitial Lung Disease autopsy death? 2 🗓 No 2 🗌 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? ပ္ 2 🔼 No Other: 1 High Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

OS Division of Vital Records, P.O. Box 68760 A To the Hospital within 24 hours a To the Funeral C completed filled

D53367 April 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajan Shyamsundar, MD 9801 Georgia Avenue, Silver Spring, MD 20902

State Registrar (Check

29b. Signa

3

re and tile o

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

			Amen	<b>Plea</b> d #17,	<b>se Type or</b> per Fh Go State o	<b>Print in</b>	Black I	<b>ndelik</b> artme	<b>ole In</b> l	k. Ens lealth	sure A	<b>III Copie</b> Mental Hy	s Ar	e Legi	ble.		
		•	For State Registrar					rtificat					Reg. N	20	10	15	193
	Physicia Medi		1. Decedent's Name Willi		<sup>Last)</sup> Richard	Ноу	7					2. Date of De Month		Day 20	Year ) \ 0	3. Time o	
	Examir		4a. Facility Name (if I	not institution,		ber) He l	Laxe	4b. City	, Town, o	Location			4	c. County o		026	
Ī	Funeral Director		5. Social Security Nu 218–32–72	273	6. Sex 1	7. Age ( <i>In yr</i> s. 7 <b>5</b>	l <b>a</b> st birthday) Yrs.	If Unde Months	Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir 01/18/.	th 1935		9. Birtho	lace (State or Yland	or Foreign
	yland f show	tor	Usual Residence of I	10b. County			ty, Town or L								1	0d. Inside C	
	the Mar or 28a- e notifie	Direc	Maryland  10e. Street and Num	Wico	mico	Ç	Quanti		p Code			I	10g. (	Citizen of WI	hat Coun		2 <b>X</b> No
	th with ms 23a must b	<b>Funeral Director</b>	22239 W	letipqu:			o I.o	11/ 5	218					USA			
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Fu	11. Marital Status  1  Never Marrie 3  Widowed 4		If Van Cive	ces? 2 \Bo	5. 13.	was Dece If Yes, spe 1  Yes				cify Yes or No- Rican, etc.)		14. Race Black Specify:	, White, e	etc.	
Z-12-0	72 hou in "natu Medical	mplet			st grade completed)		i (Give	edent's Usu kind of wo	ork done o	ation during mos	st of worki	ng	16b.	Kind of Bus	iness Inc	lustry	
12121	d withir tygiene ther the	Se Co	Elementary/Seco		College (1-							tractor		consti	cuct	ion	
Vanc	Ild be file Mental H narked o	To E	17. Father's Name (F Dr. John			•						e (First, Middle, nia Hic -		n Surname)			
NGm Mary	nd 2 shou ealth and m 27 is m		19a. Informant's Nar Nina Par		ip (Type, Print) Spouse		19b. Mai <b>22</b>	ing Addres 239 W	s (Street a	and Numb Yuin	er or Rura Rd • 1	Route Numbe Quanti	er, City o	MD 2	1856	ode)	
William HOV altimore, Maryland 21215-0036	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1  Burial 2  4  Donation	Cremation	3 ☐ Removal from specify)	State C	Place of Disp cemetery, cre lisbur	matory or	other plac			Date /2010		Location - C Salisb	-		
Balt	permit. Depart Import any inj		21. Signat re of Fun		censee		2	4161114 501	oway: Snow	Fúne Hill	ral F	Home, P , Salis	rof bur	essior y, MD	nal 2 2180	Associ 04	ation
	4550m3/452W		shock, or hear	t failure. List or	complications that can	aused the deat ch line.	th. Do not en	ter the mod	de of dyin	g, such as	cardiac o	r respiratory ar				Approxima Interval Bet	te ween
4	Pnysician/ Medical Examiner		Immediate Cause (F disease or condition resulting in death)		a. ME7 Due to (c	A-S Ticor as a conseq	uence of):	1057	TAT	2 (	CAN	cien			-	Onset and	Death
		iner	Sequentially list con it any, leading to im- cause. Enter Underl	mediate	b. Due to (c	огаз а солѕец	uence of).	-					_				
0	aw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal Examiner	Cause (Disease or ii that initiated events resulting in death) L	injury	·	or as a conseq	uence of):										
3876(	rtificate ling phys e as the	/Medi	IF FEMALE:		d								-1	19			
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent printhe past 12 mm 1 Yes 2 The graph of the graph of	nonths?		Birth 2 ☐ Feta nant at time of a	al death 3	☐ Ectopic ☐ Other (s		у			10	23d. Date Mont		•	Year
P.0	s that the second secon	þ	Part II. Other signific	cant condition	ns contributing to de	eath but not res	sulting in the	underlying	cause giv	en in Part	: I.			use contrib			
ords	v requir s been s should	Completed										1 🗆 24a. Was	an	24b. We	ere autop	ably 4 🗆	available
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ital	ician: certific rector,	Be	25. Was case referred examiner?  1  Yes 2	d to medical	Hospital:				Oth	ar.	ath (Check	, , , ,				1, 64	, o P
<u></u>	Phys or this eral di	e: 10	27. Manner of eath		28a. Date o		28b. Time o		OA Injury	4 ∟ N		me 5 🗌 Resid 28d. Describe h		*		HOSP	CIE
on o	ending aath. or: Afte he fun	Certificate:	Natural Accident Suicide	5 Pending Investiga 6 Could n	ation	h, Day, Year)	injury	М	work 1 $\square$	? Yes 2. □	_			,			
Divisi	ital or Att ins after d al Direct led in by 1		4 Homicide	determin	28e. Place o	of Injury - At ho g, etc. (Spec <i>if</i> y		reet, factor	y, office			28f. Location (\$ City or Tow			or Rural i	Route Numb	pe <i>r</i> ,
	le Hospi n 24 hou e Funer Jeted fill	Medical	29a. Certifier (Check 2 only one) 3	Medical Ex	Physician: To the be caminer: On the basis Nurse Practioner: To	s of examination	n and/or inve	stigation, in	my opinio	n, death o	ccurred at	the time, date a	nd plac	e, and due to	o the cau	se(s) and ma	nner stated.
			29b. Signature and ti						c. License	number			29d. D	ate signed (			
	5 IMP		30 Name and address	ss of person w	ho completed cause	of death (Item	1 23a) (Type,	Print)	U	005	890	by u		7121	100		
			attende	y WA	ny 1	00 130	p 1	733	, 5	ser	> BU	by u	2	21	80	2	
	Stat Registra	e ar	31. Date filed (Month,	APR 3 0	2010	gistrar's Signa	D. A	back									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04/27/2010 Edna Elizabeth Hutchinson 7:55 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death St. Leonard **Examiner** County of Death 1053 Kings Creek Drive Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Months Days Hours Min 06/09/1937 Pennsvlvania Director 215-34-3241 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Calvert St. Leonard 1 🗌 Yes 2 🖾 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20685 1053 Kings Creek Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2 2 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Worker Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental H permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ew ဂ Daniel Rice Edna Ranck Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Cartney / Daughter 5140 Chalk Point Road, Sest River, MD 20778 20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 05/01/2010 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Lee Funeral Home Calvert, 22. Name and Address of Facility SAM J. Goff 8125 Southern Maryland Blvd., Owings, MD 20736 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Pregnant at time of death ed by the a detached f Yes 2 No 9 Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 W Unknown Completed 24b. Were autopsy findings available 24a. Was an Jas autopsy prior to completion of cause of death? page certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **■** Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accider Suicide Accident

Box 68760 P.O. Physician: The law requires Records, **Division of Vital** the Hospital or Attending Pl thin 24 hours after death. the Funeral Director: After the impleted filled in by the funera

Maryland 21215-0036

Baltimore,

Jew 5 Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rafik Nasr, 225 Towne Square Drive, Lubsy, MD 20657

31. Date filed (Month, Day, Year) 32. Registra Signature

Could not be

determined

4 Homictde

29a. Certifier

(Check

only one) 29b. Signature and title

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D37588

28f. Location (Street and Number or Rural Route Number,

April 30, 2010

29d. Date signed (Month. Dav. Year)

City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month F. 1:10 am Rubu Haney April. 29 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville Caseu House Montgomeru 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Rirth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Days 578-01-8039 99 Virginia Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3701 International Drive. #209 20906 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Walter Hawkins Marian Jordan Waddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Haney - Son 10116 Queens Circle, Ocean City, Maryland 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Cedar Hill Cemetery 05/03/2010 4 ☐ Donation 5 ☐ Other (Specify) Suitland. Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licer ala 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Brain Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immedit cause. Enter Underlying Cause (Disease or iinjury Director or electric administration of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Other (specify) Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗓 Other (Specify) HOSpice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) April 29. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Nicole Christenson.

APR 3 0 2010

31. Date filed (Month, Day, Year)

6001 Muncaster Mill Road, Rockville, Maryland 20855

CRNP,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ene Day 19144 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical renter Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 - M 2x- F Months Days Hours (Month, Day, Year) 01/25/48 S Country) **Director** 62 249-86-6950 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk 1 ¥ Yes 2 □ No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 69125th 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Raltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Divorced 4 Divorced Specify. "natural" Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. sant, If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) GSI Food Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Richard Wright SR Charlette DeLesline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6912 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. Walter Hoque Husband 5th Ave Dundalk, Md 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/01/10 Silver, Spring Md Gate Of Heaven 21. Signature of Funeral Service Licensee <sup>22</sup> Snead Address of Facility Home & Cremation 077 Georgia Ave NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final brain Physician/ anoxic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ventilato Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury -tran and that initiated events resulting in death) Last Due to (or as a consequence of) burialsigned by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No jo Pregnant at time of death 5 Other (specify) Month Day Year be detached 9 Unknown 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury nours after death.

neral Director: After the filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident 1 Tes 2 No Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of 29c. License number RES-OCC person who completed cause of death (Item 23a) (Type Eastern Avenue, Battimore, MD, 21224 MID

State

Registrar

31. Date filed (Month,

day, Year)

8

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Date of Death Month Day 2010

4b. City, Town, or Location of Death

Westminster

Westminster

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nov 26, 1958

Johnson

7. Age (In yrs. last birthday)

51

Yrs.

3. Time of Death

12:20 a M

9. Birthplace (State or Foreign Country)
Georgia

April 29,

4c. County of Death

Carrol1

1	Physicia /Medic Examin	al
	Funeral Director	

Cherl Denise

1 □ M 2 🛣 F

4a. Facility Name (If not institution, give street and number)

1225 Woods Road

5. Social Security Number

212-72-5080 Usual Residence of Decedent

	10a. State	10b. County		10c. City, Towi	or Loca	ation					10d. Inside City Limits
호	PA	Adams		Lit	tles	stown					1 ∐Yes 2 🙀 No
ie					0_0	10f. Zip Code			10g. (	Citizen of What Co	untry?
	750 Se	11 Stati	on Pd			i	17340			ΠCΔ	
ner	11. Marital Status	II Deach	12. Was Decedent B	Ever in U.S.	13. W			in? (Specify Yes or N	0-		rican Indian.
	1 Never Marri	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	No				Puerto Rican, etc.)		Black, White	
by	3 🗆 Widowed	4 Divorced	If Yes, Give Year or Dates:		11	⊥Yes 2, No	Specify:			Specify:	White
etec	(Spec	15. Decedent's Ed	lucation	16a.	Decede	ent's Usual Occup	pation	nd usa ulsin u	16b.	Kind of Business/	Industry
hpl	Elementary/Secon			+)			d)	or working			
ပ္ပ					C1	erk	1		R	ite-Aid	
	17. Father's Name (	First, Middle, Last)					18. Mother	's Name (First, Middle	e, Maide	en Surname)	
မ											
			_	- 1					-		
			Husband								7340
	,		Removal from State	20b. Place of cemeter	Disposi y, crema	tion (Name of itory or other pla	ce)	Date	20c.	Location - City or	Town, State
			<u> </u>	Carrol							
	21. Signature of Fur	neral Service Licen	see								
	Jon.	rr 14								er, MD	21157
	snock, or near	t fallure. List only	olications that caused one cause on each lin	the death. Do r	ot enter	0		ardiac or respiratory	arrest,		Approximate Interval Between
	disease or condition		a	Lun	9	Can	cer				Onset and Death
	resulting in death)		Due to (or as a	a consequence o	لوه						
<u>.</u>	Şequentially list con	ditions,	b		0						
Ē	cause. Litter Under Cause (Disease or i	nediate Tyling piury	Due to (or as a	a consequence o	or):					15	
хач	that initiated events		C	CONSORTION	4).						
			240 15 (61 45 1	2 consequence c	11).						
dic			.d								
Š	IF FEMALE:		23c. If yes, outcome of	of pregnancy						00d D-t( d-1)	
ciar	in the past 12 g	nonths?	1 Live birth	2 Fetal death					İ	Month	Day Year
ysi	9 ☐ Unknown	JNO	9 ☐ Unknown		000	other (apcolly)					
	Part II. Other signific	cant conditions co	ontributing to death bu	t not resulting in	the und	erlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
D D		Seizu	LYES					1 🗆	Yes :	2	obably 4 Unknown
ete		Diah	0+08		-					Odb Wore out	Annu findings available
臣		0 1						— auto	psy	. prior to d	completion of cause of
	25 Was assa referre	od to medical	on Ca	MCGX				1 □ Yes	2 🗹 N	lo 1 ☐ Yes	2 No N/A
<b>m</b>	examiner?	/	Hospital:			Oth		-	/		
<u> </u>	27. Manner of Death		28a. Date of Injur	y 28b. T		3 LI DOA	4 L Nurs				oify)
ᅙ	1 Natural	5 Pending investigation	(Month, Day,	(Year) In	jury				11044 1111	ary occurred	
<u> </u>	3 🗌 Suicide	6 ☐ Could not be			m, street				Street a	and Number or Bu	ral Route Number
ert	4 ☐ Homicide	/	building, etc.	(Specify)		,					rar riodic ryomber,
	29a. Certifier	Certifying Phy	/sician: To the best o	f my knowledge,	death o	ccurred at the tir	me, date and	place, and due to the	cause	(s) and manner as	stated.
gic	(Check only 2 one)	2∐ Medical Exam	iner: On the basis of	examination and	/or inve	stigation, in my o	pinion, death	occurred at the time	date a	nd place, and due	to the cause(s)
Ž	29b. Signature and ti	tle of certifier	1 1			29c. Licens	e number		29d. D	ate signed (Month	n, Day, Year)
	$\rightarrow$	rul	nll			DC	065	5246		4/29	110
-	30. Name and address	ss of person who c	ompleted cause of de	ath (Item 23a) (	Type, Pri	nt) Ni	AR U	MID		11301	
	912 U	Jasher	ngton	Rd i	ne	stru	nela	MD	2	1157	
е	31. Date filed (Month	, Day, Year)	32. Registra	r's Signature			4-1>+€	A			
r	P	PR 3 0 2	010 Seneu	n B.	Soa	wes					
)1		3			1						
		PA  10e. Street and Nur  750 Se  11. Marital Status  1 Never Marri  3 Widowed  (Spec  Elementary/Secon  12  17. Father's Name (  19a. Informant's Na  William  20a. Method of Disp.  1 Burial 28  4 Donation  21. Signature of Ful  23a. Part 1. Enter the shock, or heal Immediate Cause (I disease or condition resulting in death)  Sequentially list confiancy, leading to immediate Cause (I disease or condition resulting in death)  IF FEMALE:  23b. Was decedent in the past 12 I Natural in the past 12 I Natural I Natura	PA Adams    10e. Street and Number   750 Sell Static   11. Marital Status   1   Never Married   2   Married   3   Widowed   4   Divorced   15. Decedent's Ec (Specify only highest grater   12   12   12   12   17. Father's Name (First, Middle, Last)   19a. Informant's Name/Relationship (William Johnson   20a. Method of Disposition   1   Burial   2   Cremation   3   4   Donation   5   Other (Specify 21. Signature of Funeral Service Licen   23a. Part 1. Enter the disease, or companies of shock, or heart failure. List only the service of shock, or heart failure. List only that initiated events resulting in death)    Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death)   Last   2   No   9   Unknown   Part II. Other significant conditions or   27. Manner of Death   1   Palatural   5   Pending investigation   29   Unknown   29   Unknown   29   Cause (Disease of injury that initiated events   1   Yes   2   No   9   Unknown   29   Unknown   29   Unknown   29   Medical Examone)   29   Signature and title of certifier   29   29   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR 3 0 2   31. Date filed (Month, Day, Year)   APR	PA Adams    10e. Street and Number   750 Sell Station Rd.     11. Marital Status   12. Was Decedent   Armed Forces?   1   Yes. Give Year or Dates:   1   Newer Married 2   Married   1   Yes. Give Year or Dates:   1   Yes. Give Yes. Give Year or Dates:   1   Yes. Give Yes. Gi	PA   Adams   Litt	PA   Adams   Littles	PA Adams Littlestown    10e. Street and Number   10f. Zip Code   PA   Adams   Littlestown   100, Zp Code   17340   17340   17340   17340   17340   17340   17340   17340   17340   17340   18341   18451   18	PA Adams    Interpretation   Interpretat	PA   Adams   Littlestown   10, Zip Code   109, 107, 200, 200, 200, 200, 200, 200, 200, 2	PA   Adams   Littlestown   109, 200ce   109, Citizen and What Co   17340   USA   11. Marsial Status   12. Mars Decedent Citer in U.S.   17340   USA   11. Marsial Status   12. Mars Decedent Citer in U.S.   17340   USA   11. Marsial Status   12. Marsial Status   12. Mars Decedent Citer in U.S.   17. Marsial Status   17. Part of Fickan, etc.)   18. Marsial Status   17. Part of Fickan, etc.)   18. Marsial Status   17. Part of Fickan, etc.)   18. Marsial Status   18. Ma	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#5perFH, G904,6/1/2010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🗸 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April  $2^{3}$ ,  $201^{\circ}$ **Physician** 12:45ам Violet G Jaquay /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery 12107 Hunters Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. **Funeral** Days Min Hours 1 □ M 2 😾 F 86 New York 12/15/1923 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hygiene. "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State d other than "natural", or items 23a or 28a-f show event, it e Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Rockville Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 USA 12107 Hunters Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, If an once. School Cook 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Rath Graff Jesse ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12107 Hunters Lane Rockville, Md 20852 Sharon Saunders/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4/23/2010 Chesapeake Crem. Beltsville, Md 4 □ Donation / 5 Other (Specify) 21. Signature PHILIP O.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Brain tumor /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (prisease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and Box 68760. Due to (or as a consequence of): physician a the burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ▼No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the 9 I Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been signated; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The performed' certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c D53177 April 23,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

John Wallmark M.D.

28 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10605 Concord St. #300 Kensington, Md 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician April 24, 2010 Patricia Madeline Juriansz 10:20 P.M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Gaithersburg Wilson Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) March 17,1928 Sri-Lanka Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 3√□ F 217-11-9844 82 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exxr.inver must be notified at once. Rockville MD Montgomery 1 ¥ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 199 Rollins Avenue #810 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hamilton Schokman Jenkins Constance MargaretNicolle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Sorbello/Daughter 11331 Palatine Dr., Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place).

Georgetown University April 26 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Washington, D.C. Medical Center 2010 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service /M00969 9013 Annapolis Road, Lanham, MD 20706 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** pranucles rogress, ve years disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, lary leading to minimal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No signed by the a q | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy performed? 1 Yes 2 No ours after death.

eral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Sizertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2 and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who compléted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Anddidi Fineberg, M.D.

28 2010

31. Date filed (Month, Day, Year)

APR

D0059423

301 Russell Avenue, Gaithersburg, MD 20877

26,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Leverne Kimble 23 2010 1730 ™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number 1 Year If Under 24 Hrs.
Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🏋 F June 4 Months 1952 New York Director 57 578-72**-**5138 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Me ical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Temple Hills 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2017 Gaither Street 20748 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. 3 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12th Legal Assistant Private Industry injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Kimble permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Emma Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Kimble/Son 2017 Gaither Street, Temple Hills, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park: 5/3/10 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, N.W., Washington, DC2001 M00996 23a- Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) IVer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exam attending physician and for use as the burial-transit Sepsic that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 🔲 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown the 9 Unknown ed by t detach signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 2 🗌 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 11 Natural 5  $\square$  Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотретер 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 04/26/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Registrar's Signature

2010

				Please	Type or Prin					-		gible.	
			For State Registrar		State of Ma	aryianu /		rtificate of i	lealth and N Death		Reg. No.	0.10	15001
			Decedent's Name	e (First, Middle, La	st)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Leva	la B.	Wilson	NK	not		_	5	4	2010	1200PM
	Examin			_	re street and number)				r Location of Death		(3)	nty of Death	
,			Oakland  5. Social Security N		& Rehab Co	enter e (In yrs. last	hirthday)	Oaklan		8. Date of Birt	1		place (State or Foreign
	Funeral Director		234-44-		1 M 2 □ XF 8		Yrs.	Months Days	Hours Min.	(Month, Da)	, Year)		place (State or Foreign of land
	0		Usual Residence of	Decedent	1 0					11/20/			
	sryian show	_	10a. State	10b. County		10c. City, To						'	0d. Inside City Limits 11√∑Yes 2 ☐ No
	8a-f	Director	WV	Grant		Gorı	mania	10f. Zip Code			10g. Citizen o	of What Cour	
3	Mith t		10e. Street and Nur P.O. Bo					26720			•	ed Sta	
	ms 23	Funeral	11. Marital Status	<u>x /4</u>	12. Was Decedent	Ever in U.S.	13. \	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-		lace - Americ	
	or iter			ied 2 Married	Armed Forces? 1 ☐ Yes 2 📆 I If Yes, Give	No		f Yes, specify Cuba 1 □Yes 2 🕅 No	an, Mexican, Puerto Specify:	Hican, etc.)	Spec	lack, White,	etc.
3	illed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or items 23a or 28a-f show ent, the Madical Examir ar must be notified at	d by	3 Widowed		Year or Dates:							Whi	
	"natu	lete	(Spec	15. Decedent's E cify only highest gra	ducation ade completed)	1	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Kind of	Business/In	dustry
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7	il Hyg other rent, I	Be C	17. Father's Name	(First, Middle, Last	)	<del></del>			18. Mother's Nam	ne (First, Middle,	Maiden Surn	ame)	
2	Menta Menta rrked rrked	To E	Andrew	Jackson A	Armentrout				Gracie	Beatri	ce Fol	еу	
8	2 should be n and Mental is marked c raumatic ev	•		ame/Relationship		1			and Number or Ru			vn, State, Zip	Code)
	1 and Health em 27 ether tr			Knotts,	Husband	20h Blac			, Gormani	Date WV	26720 20c. Locatio	n - City or To	own. State
5	permit. Pages 1 and 2 should be filed within 7.2 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Macinal Examination at the matter once.			Cremation 3	Removal from State	1		sition (Name of matory or other place		6/2010		rd, WV	, 2000
	artmer srtant srtant Injury		4 ☐ Donation  21. Signature of Fu	5 ☐ Other (Special Service Lice		вауа		emetery  Name and Addre					
מ	permit. Departr Imports any Inju		Vot	the same	1 weite	_		David A.	ss of Facility Burdock cond St.	Funeral Oaklan	Home,	P.A. 21550	0
			23a. Part 1. Enter 1	the disease, or com	plications that caused one cause on each li	the death. [							Approximate Interval Between
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	arn ce ttendi or use	an/I	23b. Was deceden		23c. If yes, outcome 1 Live birth	2 Fetal de	eath 3[	Ectopic pregnanc	су			Date of deliv Month	ery Day Year
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	res mar u signed by be detac				contributing to death b	ut not resultir	ng in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use c	ontribute to t	he cause of death?
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2	death death ctor: y the	ficat	2 Accident 3 Suicide	investigatio 6	28e. Place of Inj	ury - At home	e, farm, str	eet, factory, office		28f. Location (	Street and Nu	ımber or Rur	al Route Number,
2	a after safter Dire	Certification:	4 Homicide	determined	building, et	c. (Specify)				City or To	vn, State)		
:	To the hospital of Attending Priysician; The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the law and the funeral director.		29a. Certifier (Check only	1☐ Certifying P	hysician: To the best miner: On the basis of	of my knowle	edge, deat n and/or ir	h occurred at the to	ime, date and place	e, and due to the	cause(s) and	d manner as ce, and due t	stated. to the cause(s)
	the F the F the F	Medical	one)		and manner st			29c. Licens			29d. Date sig		
1	Mit Coi		29b. Signature and	ande of certifier	In Isla	1000			CT337	2	5	14/10	7
			30 Name and add	ress of person who	completed cause of c	leath (Item 2	3a) (Type			ノ <u></u>			
		5			Johnson, M				Street, C	akland,	MD 2	1550	
	Sta	te	31. Date filed (Mor	nth. Dav. Year)	32 Registr	raris Signatur	e	Lacks	1				

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

			For State	State	of Ma	ryland / De					lental Hy	giene	2010	1-12	202
			Registrar  1. Decedent's Name (First, Middle)	- ( 4)			ertifica	te of L	Death		0.0-1/.0	Reg. Not	2010	C	<u> </u>
	Physicia	an	John Robert Ke								2. Date of De Month	Day		3. Time of	
***	/Medic Examin		4a. Facility Name (If not institution		ımber)		4h Cit	/ Town or	Location of	of Death	May	2,	2010 County of Death	8:00	A <sup>M</sup>
age of	Examin	ei	751 Beckman's		,	hd		vanto		or Doddin			Garrett		
	Funeral		5. Social Security Number	6. Sex		(In yrs. last birthd	y) If Und	er 1 Year	If Under		8. Date of Bir	th	9. Birth	place (State o	r Foreign
i.	Director		268-38-9429	1 XM 2 □ F	67	Yrs	. Months	Days	Hours	Min.	(Month, Di 10/25	1942	2 Ohi		
	and w		Usual Residence of Decedent  10a, State 10b, County			10c. City, Town or	Location							10d. Inside Cit	ne l. Impika
	/aryla	JO.				**								1 ⊠Yes	
	the N	Director	MD Garr  10e. Street and Number	ett		Swanto		ip Code				10a Citi:	zen of What Cou	71	
	3a or		751 Beckman's	Pennigula	Roa	nd		21550							
	death	Funeral	11. Marital Status	12. Was Dec	edent E		3. Was Dec	edent of Hi	ispanic Ori	igin? (Spe	ecify Yes or No		ited St. 14. Race - Ameri		
9	after or ite	/ Fu	1 ☐ Never Married 2 💢 Mar	ied Armed F 1 □Yes If Yes, G	2 XN	0	if Yes, sp		n, Mexicar Specify:		Rican, etc.)		Black, White,	etc.	
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<u>la</u>	should be to and Mental marked oumatic eve	To B	Frank G. Kella	am					E1	eano	r Hacke	enbur	g		
Maryland	sho and sum sum		19a. Informant's Name/Relations	hip (Type. Print)		19b. Ma	iling Addres	s (Street a					Town, State, Zij	Code)	
	es 1 and 2 of Health If item 27 I or other tra	1.4	Susan Kellam,	Wife						nisu	la Rd.,	Swa	nton, M	2155	0
ore Ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  1 K Burial 2 Cremation	3 ☐ Removal from	State	20b. Place of Dis	position (Na rematory or	ame of other place	e) :	D	ate	20c. Lo	cation - City or To	wn, State	
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ga	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service	Licensee			22. Name a	and Address $\mathbf{d} \cdot \mathbf{A}$ .	s of Facilit Burd	ock :	Funera]	Hom	e, P.A. D'21550		
		1	23a. Part 1. Enter the disease, or	complications that	LV DUODE	the death. Do not							D'21550	Approximate	
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į.	Physician /Medical	i	disease or condition resulting in death)	a. ME	A-51	alle	par	KIE	Alic	C	TH CER			4 46	405
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×	certifi nding ise as	/Me	IF FEMALE:	23c. If yes, ou	tcome o	f pregnancy							21 2-1-1	- <del></del>	
go	s atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live	birth 2	Fetal death	3 ☐ Ectopic 5 ☐ Other (s		,			2	3d. Date of delive Month	,	e ar
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,	ding Physician: The law requires that the death certifin, h. After this certificate has been signed by the attending p. funeral director, page 2 should be detached for use as	by P	Part II. Other significant condition	ons contributing to d	eath but	not resulting in the	underlying	cause give	n in Part I.	,	23e. Did t	obacco us	se contribute to t	he cause of de	eath?
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5	Phys this (	၉	1 Yes 2 → Ho  27. Manner of Death	1		t 2 ER/Outpat			4 LI NU				☐Other (Specif	fy)	
SION	ding F h. After funera	틸	1 ☑ Natural 5 ☐ Pending	9 1 .	th, Day,	Year) 28b. Time Injury	/ M	28c. Injury Work′ 1 □ ∨	rat ? ′es 2 □ ľ		28d. Describe I	now injury	occurred		
20	Atten	fica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place	of Injur	y - At home, farm, :			63 2 🗀 1		8f. Location (	Street and	Number or Rura	al Route Numb	oer.
5	al or	Certification: To	4 ☐ Homicide determ	build	ng, etc.	(Specify)					City or Tov	vn, State)			
	ospit hours unera		29a. Certifier 1 Certifyin	g Physician: To the	best of	my knowledge, de	ath occurre	at the tim	ne, date an	id place, a	and due to the	cause(s)	and manner as s	stated.	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	Urle)	Examiner: On the band man	ner state	examination and/or			_	th occurre	ed at the time,	date and	place, and due to	the cause(s)	
	with Co.	2	29b. Signature and title of certifier	, –			29	c. License	number	110	,	29d. Date	signed (Month,	Day, Year)	
•			1/4	1/				110	061	JU 1	/	>	17/10	/	
		2	30. Name and address of person of Dr. Kenneth	E-				+h C	troct	00	kland,	MD	21550		
	Stat		31. Date filed (Month, Day, Year)	_ 1 32 F					rreet	, Ud.	rrand,	LID	Z1330		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Agnes Kulesa 24 0930H M Apri1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours (Month, Day, **Director** 070-20-1977 83 April New Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a c permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by Completed by Funeral 11421 Scottsbury Terrace 20876 United States Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Caucasian 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anthony Rup Frances Bielawa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Kulesa / Son 9085 Blue Jug Landing, Burke, VA 22015 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, XBurial 2 Cremation 3 X Removal from State St. Joseph's Cemetery 04/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Yonkers, NY Signature of Funeral Service Licensee 22 Name and Address of Facility
Fairiax Memorial Funeral Home M00956 9902 Braddock Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FRACTURE Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ARCHOLOD Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury M To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit WRIST A1 that initiated events Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant Pregnant at time of death 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? - CONGHEART FAILURE AFIB 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DIOSETES - HYPERTENSION - AURTIC STENISS 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2X No Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? 2 🗌 No Other: Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural Accident injury 5 Pending Division work? 1 ☐ Yes 2 🗷 No Investigation 0215AM DUWN SMIRS -12-10 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 11421 SCOTTSBURY TH 2087 pme Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D62999 04/25/2010

State Registrar

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HELEN

**KULES** 

Petek Donmez, M.D., 11119 Rockville Pike, #401, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Marth Day, Year) APR 28 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Neville Kerr 2:45 am 2010 Apri Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Jamaica 1 🗶 M 2 🗆 F Months Days Hours Director 430-70-9230 73 Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2743 Sweet Clover Court 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 3. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 X No Specify: Specify "natural", 3 Widowed 4 Divorced Black Year or Dates It of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical or 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Parole Officer New York State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ezekiah Lillian Brooks Kerr permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marks any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2743 Sweet Clover Court, Silver Spring, MD 20904 Mary Kerr - Wife Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 05/01/2010 Silver Spring, . Signature of Funeral Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the diseas shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line Immediate Cause (Final Onset and Death Physician. Intracranial Bleed disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Month 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Yes 1 ☐ Yes ∠ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertensive Crisis 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 🗓 No 2 🗌 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No Be 26. Place of Death (Check only one) Hospital: Other: 은 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? \_\_1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifiei 😠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) AME . April 25, 2010 D0064100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhikkaji Smitha. 1500 Forest Glen Road, Silver Spring, Maryland 20910 APR 28 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti Nick Lynn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** <sup>ar)</sup>1<u>935</u> 1 QM 2 🗆 F Hours Month, Day Xe Aug 22 Director 192-28-8361 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Allegany Cresaptown 1 Yes 2 XNo 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 14208 Cunningham Drive 21502 USA items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 'natural", Completed 3 Widowed 4 Divorced Korea Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) .aborer Local 616 Labor. Un. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) .. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked o ဂ္ William Lynn Nora (Bellman) Lynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14208 Cunningham Dr. Cresaptown Robin Lynn daughter MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it cemetery, crematory or other place Sunset Memorial Park injury or 1 X Burial 2 Cremation 3 Removal from State 5/10/201b Cumberland MD 4 Donation 5 Other (Specify) 21. Sin ature Funeral Septe Licensee 22. Name and Address of Ferilli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ NEVMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INFLAMMATORY DEMYELINATING POLYNEVROPAT 1 🗌 Yes 2 1 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 2 N 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Gartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce D50844 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 12 SETON DIZIVE CHMBUTZGAND MIDZISOZ (721A MD Date filed (Month. Year State Registrar

7 DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Paul Lofgren Sr. 215 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Ё́М2□ F Months Hours 06/21/1941 212-40-8431 68 Director Pennsylvania Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f short Important: ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Salisbury Wicomico Maryland 1 🗌 Yes 2 🏿 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21801 5784 Homestead Street USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) machinist Dresser Wayne Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Leonard Elmer Lofgren Anna Kmetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5784 Homestead St., Salisbury, MD 21801 Rosemary M. Lofgren/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State injury or 4/29/2010 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Burov T disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner tile to for as a nonsectioned of cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown detached 9 🗌 Unknown n signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 1 Anpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1/XXNatural 5 Pending 1 Yes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 CHEUNOIL

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31. Date filed (Month, Day, Year)

APR 30

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2010 Year Gay Barbara Lewis 5:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4225 Robinson Road <u>Huntingtown</u> Calvert **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 08-22-1926 1 □ M 2 🌠 F Months Days Hours Min. Director 579-24-8834 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏋 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4225 Robinson Road 20639 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clerk retail pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u>Alexander</u> Ofenstein Mary Agnes Hodgins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia S. Lewis, daughter 4225 Robinson Road, Huntingtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 04-30-2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilify Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 507255100 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year ed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 EN 2 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident 1 Tes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRW 10 Jonathan Lowenthal, M.D., 110 Hospital Rd., Ste. 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year April 27. 9:15 а м Robert John Laut Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3156 Gracefield Road, Silver Spring rince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min. March Day Year 1924 D<sup>Country)</sup> 579-24-8865 86 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Prince George's 1 Yes 2 No Silver Spring Mary land 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 3156 Gracefield Road, #417 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
Yes 2 \( \sqrt{No} \) Black, White, etc. Ş 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1942-45 1 ☐ Yes 2 🖾 No Specify: Specify. White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Otis Elevator other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Fannie Mabel Trussler John A. Laut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 20904 3156 Gracefield Road, #417, Silver Spring, Frances Becker Laut/Wife Baltimore, 20a. Method of Disposition 20b, Place of Disposition (Name of April 20c. Location - City or Town, State 27 1 ☐ Burial 2 🏿 🛣 remation 3 ☐ Removal from State Metropolitan Crematory 2010 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22 Name and Address of Facility ins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1½ Onset and Death Immediate Cause (Final Ph sician/ Idiopathic Pulmonary Fibrosis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Year 2 No. as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease, Diabetes Mellitus-Type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 1 ☐ Yes 2 ☐ No Yes 2x No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2X No 1 Yes ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5x Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature and title 29c. License number 29d. Date signed (Month, Day, Year) April 27, 2010 D21115 use of death (Item 23a) (Type, Print) ddress of person who ompleted ca  $\hbar$ 0215 Fernwood Road, Bethesda, MD 20817 Lee Pennington, MD 31. Date filed (Month, Day, Year)

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 11:35pM yip Sin 25. 2010 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Days Months Hours Min. 1 □ M 2 🕱 F Yrs. 09/20/1947 China 181-60-9969 62 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 🛛 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 20851 U.S.A. 5627 Pier Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗓 No Specify þ 3 Widowed 4 Divorced Asian Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unavailable Unavailable ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 5627 Pier Drive, Rockville, Maryland 20851 Kuen Lee – Son 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/29/2010 Silver Spring, MD 4 Donation 5 Dother (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final FAILURE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, ARRHYTHMIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate has birector, page 2 si autopsy perform 2 No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3

State Registrar 7207 Hanover Pkwy, #B, Greenbelt, Maryland 20768

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chandrasekhar Korapati,

28 2010

31. Date filed (Month, Day, Year)

MD,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra/MFND#19aperFH,5/11/10,BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, 2010 Year **Physician** 9:30 PM April Eun Ae Lee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 89 July 15, 1920 Director 350-52-4708 Korea Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Maryland Examiner must be retitied at anones. 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Directo MD Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10930 Bloomingdale Drive 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Asian ģ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bong Gik Kim Kyung Sin Hwang ပ Informant's Name/Relationship (Type. Print) Yung Lee, Chin Yung Kim / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10930 Bloomingdale Dr., Rockville, MD 20852 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Pk. 04/27/2010 Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home M00956 9902 Braddock Road, Fairfax, VA 22032 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WELD Immediate Cause (Final LEY KEMIA Physician CU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy sate has been signed by the atte page 2 should be detached for i Month Day 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate **%**☐No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident after death.

I Director: Af d in by the fur investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 01808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TROSE NESH 10.0 MUN 6121 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 28 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 21 per FH G904 672/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:15 PM Leydia 2 10 ma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Oakland ONRC Garrett If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/18/1911 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 □ M 2 🗓 F Maryland **Director** 214-48-3065 98 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Moderal Examinar must be notified at 1XYes 2 ☐ No Director Accident Garrett MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21520 Funeral 421 South Main Street 12. Was Decedent Ever in U.S. Armed Forces?

1 [] Yes 2 [] No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping 8 permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If Item 27 Is marked other i any Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zanie Maude Glover William Howard Kelso 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 585 Glendale RD., Oakland, MD 21550 June M. Harvey/ Daughter Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/2010 | Accident, MD Pauls Cem. 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 179 Miller St., Grantsville, MD 21536 D. Lynn Newman per DVR Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EAMS **Physician** BURIVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Bóx 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 I linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an certificate has autopsy The 1 □Yes 2 ₺No Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Provibin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1006(801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Buczynski 311 Fourth St., Suite 1, Oakland, MD 21550 N. Kenneth 31. Date filed (Month, Day Registra's Signature State

DHMH 17 Rev 1/2001

Registrar

10-03580 Joel M. Mann Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joel M. Mann	1	- For State	Sta	ate of Maryla		partment d <i>ertificate d</i>		and I	Mental	Hygiene	Don No	20	10	15212
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		4a. Facility Name (i	f not institutio	n, give street and nu	ımber)		4b. City, Town	n, or Loc	cation of De	ath		4c. County of	Death	
	H	Howard Cou	ınty Genei	al Hospital			Columbi	а				Howard		
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Months	$\overline{}$	If Under 24 Hours	Hrs. 8. Date of Min.	Birth(MN	M/DD/YYYY)	<ol> <li>Birth Foreign</li> </ol>	place (State or
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DHMH 17 Rev 1/2001 OCME 2006 OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kimberly Honth APRIL Mitchell Dawn 2120 M 20/0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Niamica ROGIANOL SKISHIRY 8. Date of Birth (Month, Day, Year) 07/25/1967 9. Birthplace (State or Foreign Country) Maryland 8. Sex 7. Age (In yrs. If Under 1 Year If Under 24 Hrs **Funeral** 1 🗆 M 2 ื F Months Days Hours 42 **Director** 216-70-5520 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of wher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🗶 No Maryland Salisbury Worcester 10g. Citizen of What Country? 10e. Street and Numbe 10f, Zip Code Funeral 21804 USA 2342 St. Lukes Road . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) WMDT Elementary/Seconday (0-12) College (1-4 or 5+) television station news director 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bonnie Lee Milliner Dale Lawrence Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2342 St. Lukes Rd., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type, Print) Freddie W. Mitchell Jr/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 27 2010 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory . Sign, ture of Furer | Service Licensee and Address of Facility 1 H Snow Hill Rd., Home Professional Association , Salisbury, MD 21804 and A. Compron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ntincian Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Tensive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death n signed by the a ld be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been six completed filled in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗀 No 1 🗆 Yes 2 🔀 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 📈 No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 🗌 No Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check

State

SABERI MD APR 30 32. Registrar's Signature 2010

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

only one

29b. Signaty

title of entific

29c. License number

0067138

100 E CARNOLL ST. SALISBURY Md 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mary Darsell Miles 2:13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Nov. 12, 1913 96 Hours Min 1 □ M 2 🏻 F Maryland 218-05-2033 Director Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Berkeley Falling Waters West Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25419 USA 2356 Nestle Quarry Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ※※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: 3XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookeeper Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည William R. Beam Mary F. Teal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon W. Miles, Jr. - Son 2356 Nestle Quarry Rd. Falling Waters, WV 25419 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 3 Berneval from State XXXBurial 2 Cremation Greenlawn Mem. Park 05-03-2010 Williamsport, Maryland 4 Denation 5 Other 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Fineral Se 425 S.Conococheague St. Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the board. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 5 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 21216 1 Yes 2 Ino 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has l autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Tes 2 4100 ပ 1 Inpatient ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending work? Natural 2 🗋 No death. 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 400611 WAShington 251 E Au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05H-4 MD

State Registrar Rencisco

MAY 0

31. Date filed (Month, Day, Year)

0

niels

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 26, Day 2010 Year Physician/ 12:25 рм Alwyn L. Merrill, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1135 University Blvd., West, #1110 Montgomery Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) D.C. Days Min. 1 X M 2 D F Months Hours July 14, 1939 219-36-9582 70 Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No MD Montgomery Silver Spring 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20902 1135 University Blvd., West, #1110 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, ö ģ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 x No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Sales Manager Retail injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o မ Alwyn Lowe Merrill, Sr. Ida Mae Threatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Bradley Court, Rockville, MD 20851 19a. Informant's Name/Relationship (Type, Print) Saul M. Honigsberg/Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rockville Cemetery
Association 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 29 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Myocardial Infarction immediate Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Coronary Thrombosis immediate Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Atherosclerotic Coronary Disease several year: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hypertension several year: Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown P.O. ρ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Alchohol Abuse-Remote History Records, 1 Tes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica eted filled in by the funeral director, p of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Kesidence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d, Date signed (Month, Day, Year) April 27, 2010 D09215

State Registrar 10313 Georgia Avenue, Suite 207, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signatu

Lawrence D. Marcus,

31. Date APR 2 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Margaret Mancuso April 27, <sup>D</sup>2010 Physician/ 11:00 p M Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Holy Cross Hospital Silver Spring 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** March 22 <sup>ear)</sup>1914 Days Hours 1 □ M 2 🏲 F 96 Pennsylvania 577-42-8768 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State death with the Maryland the Medical Examiner must be notified at Director 1 🗌 Yes 2 🎦 No 28a-f Montgomery Maryland Olney 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 23a USA 20832 17527 Longview Lane 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Health and Mental Hygiene. Item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Floral Store Florist unknown Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I မ Anna Fedelen Michael Thur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25512 Jarl Drive, Gaithersburg, MD 20882 Michael Mancuso/Nephew or other item 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2010 Silver Spring, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Francis J. Collins Fu 500 University Blvd. 21. Signature of Funeral Service Licensee Funeral Home Inc. d. W., Silver Spring, MD 20901 or complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Systemic Inflammatory Response Syndrome Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a nonsequence of): anding physician and use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Yes 2XXNo ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) the funeral director. 25. Was case referred to medical Be examiner?
1 Yes 2 No Hospital 1 X Inpatient 2 ER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? XX Natural 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

P.O. Box 68760 Division of Vital Records, Hospital or Attending 24 hours after deat Funeral Director: completed filled in by within 2

2

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 4/28/10 D0061937 mi LU u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVER SPRING MD FOREST GLEN RD 1500 CANDACE L. WILSON MD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month RIL Day 8 5:38A M Michael Peter Miller Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death timore Joseph Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Sept. 16, 1986 1 X M 2 □ F Hours 213-25-8235 Pennsylvania 23 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Garrett Grantsville 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 19 South Yoder St. 21536 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 K Never Married 2 Married 1 Yes if Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Tree Trimming Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Miller Karin Naslund permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter H. Miller/Father Box 599, Grantsville, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Country Side Crematory May 3, 2010 4 Donation 5 Other (Specify) Davidsville, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. mall P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of beart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. PNEUMONITIS Medical resulting in death) Due to (or as a consequence of): Examiner DAYS MULTISYSTEM ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events DAYS SHOCK Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical ARRYTHMIA 12 Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte in the past 12 months? Month Pregnant at time of death
Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy X Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital Other: မ 2 No 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year) State

Medical

Homicide

29a. Certifier (Check

only one)

6 Could not be

determined

Registrar DHMH 17 Rev 7/2009 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

TOWSON.

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DRIVE

28f. Location (Street and Number or Rural Route Number,

MARYLAND

29d. Date signed (Month, Day, Year)

29

2010

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Usloci 57

at

's Signature

M

Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 4 2010

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 04 Year Ortiz 10:55 laniel 2010 ( Crozoco OS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hospital Laurel Regional Trinu Uccraes If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 0408/2010 5. Social Security Number, 7. Age (In yrs. last birthday) Birthplace State or Foreign Country) Hours | Min. 1 M 2 □ F Months Days Aryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No aurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code United States 20724 236 010 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 XYes 2 No Specify. Specify: Hispanic 3 Widowed 4 Divorced Mexican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lnfant Infant 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Urtiz Favon Balbuena Dehira Daniel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dehira Pavon Balbuera - Mother XVE Laurel MD 20724 236 Old Line 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12 4 125pz Lewel 4 □ Donation 5 ☑ Other (Specify) 21. Signature of Funeral Service Licensee ( 1105) 22. Name and Address of Facility Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Extremo disease or condition resulting in death) Due to (our s a consequence of): Leura tur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 I I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed? 25. Was case referred to medical examiner?

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MID

**Funeral** 

Director

28a-f show

Director

Funeral

ģ

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner marke neither at

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic event, II a Median injury or other traumatic events.

72 hours after death with

Maryland 21215-0036

3altimore,

Examiner burial-transit and attending physician for use as the burial Physician/Medical ed by the a cate has been signed by page 2 should be detacl <u>ک</u> Completed certificate Be

IF FEMALE:

1 Yes 2 No

27. Manner of Death

Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a, Certifier

Medical

law requires that the death certificate be executed

Box 68760,

P.0.

Records,

Division of Vital

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certification: To

State

LAUREL -

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 → patient 2 □ ER/Outpatient 3 □ DOA 28b. Time of 28d. Describe how injury occurred

> 29c. License number 014774

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 ☐ Yes 2 X No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AZIZ MD. 7300 SHAHID

and manner stated.

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

DUSEN RI. 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State AMEND#9, 10g, 12, 15, 16ab, 17, 18, 19ab Registrarper FH 4=30-2010, BWW, MCC Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AMES Physician/ Month Day OFFUT 5 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SPRING HOSPITIA ONTGOMER CROSS UER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) Month, Day 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Hours Country) 20-12 **Director** MD Usual Residence of Deceden iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No SILUER PRINC MONTGOMERY 10e. Street and Number 10g. Citizen of What Country? USA Funeral 1203 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or it
any injury or other traumatic event, the Medical Examine once. Completed by 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Laborer 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 6th College (1-4 or 5+) Funeral UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert, Offutt Elizabeth Carter 19a. Informant's Name/Relationship (Type, Print)

DOTOTHY Johnson/sister 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
703 Lenmore Ave#F3; Rockville MD 20850 41054 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Remova netery, crematory or other place 4/30/10 4 ☐ Donation 5 ☐ Other (Spec Ardent Cremation Sv Hanover, MD Snowden Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -Pnysician/ ARDIAC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) PHEUMONI attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Division of Vital Records, RENAI 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Yes 2 No Yes 2 No Physician: director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aftr completed filled in by the fun 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 64100 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

HB

3 0 2010

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Marylan	-		of Heal of Dea		Mental Hyg		2016	5220	
	Physicia	ın/	1. Decedent's Name (First		· -	0.000					2. Date of Deat	_	- Year	3. Time of Death	
	Medic Examir	cal	Maria 4a. Facility Name (if not ins	Argel		Orell	Lana	4b City T	own or loca	ation of Death	April	_	, 20 1°0 County of Death	3:50а м	
أميد	LAAIIII		19900 Wa		Cour	t		Ger	manto	own			Montgo		
	Funeral Director		5. Social Security Number none	6. Sex 1 🗆	M 2 🔀 F 7.	Age (In yrs. la	st birthday) Yrs.	If Under	Year If U Days Ho	urs Min.	8. Date of Birth (Month, Day, June 5	Year) 9 3	9. Birth	place (State or Foreign atry) Salvador	
	nd how at	'n	Usual Residence of Deceded 10a. State 10b.	lent County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Maryla 28a-f s otified	Director		ntgome	ery	Ge	ermant	town						1 Yes 2X No	
	with the 23a or ist be n	eral D	10e. Street and Number 19900 Wa	terloc	Cour	t		10f. Zip 6	code 20874		1	•	en of What Cou	•	
	death r	Funeral	11. Marital Status		2. Was Decede Armed Force	es?	i. 13. V	Vas Decede Yes, specif	nt of Hispani y Cuban, Me	c Origin? (Sp	ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White,	can Indian,	
920	rs after Iral", or Exami	ed by	1 ☐ Never Married 2 3 🙀 Widowed 4 ☐ D		1 Yes 2 If Yes, Give Year or Date		1		□ No Sp	ecify:	ran	S		hite	
15-0	Specify: Specify: First Salvadoran   Specify: First Salv						d of Business Ir	ndustry							
212	within giene. ner tha t, the N		Elementary/Seconday  0	(0-12)	College (1-4	or 5+)		nemak				Ov	vn Home	e	
land	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med	To Be	17. Father's Name (First, Nunknown	fiddle, Last)							ne <i>(Fir</i> st, <i>Middle, M</i> Lsca Ore				
Maryland 21215-0036	d 2 should alth and M 1 27 is mar er traumat									Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Waterloo Court Germantown, Md 208					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I it item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 □ Cre 4 □ Donatign 5 □	mation 3 🔽 🛭	emoval from Si	tate Ce	lace of Disposemetery, crem	natory or oth	e of per place)		Date 5/2010	S	ation - City or T San Mic	quel,	
Balti	21. Signatura of Funeral Service treessee  22. Signatura of Funeral Service treessee  23. Signatura of Funeral Service treessee  24. Columbia Blvd. Silver Spr								SERVIC	Ξ,Ρ.Α.					
	n n		23a. Part 1. Enter the disc shock, or heart failur		cause on each	line.								Approximate Interval Between Onset and Death	
đ	Physician/ Medical Immediate Cause (Final disease or condition resulting in death)  Chronic obstructive pulmonary disease  Due to (or as a consequence of):									5yrs.					
	Examiner	e.	Sequentially list condition	s, b			4								
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or ilinjury that initiated events  c.												
0	cate be executed physician and the burial-transit	edical E	resulting in death) Last	L	Due to (or	as a consequ	ence of):								
8760	tificate ng phys as the		IF FEMALE:	- 0								- 10			
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	allt.		th 2 🗌 Fetal nt at time of d	Ideath 3	Ectopic pr   Other (s <i>p</i> e				23	3d. Date of deliv	Date of delivery Month Day Year	
P.O.	s that the		Part II. Other significant of		_		ulting in the u	nderlying ca	use given in	Part I.				he cause of death?	
rds,	require been signould b	eted	hypertens	ion, a	ementi	.a								bably 4 Unknown	
Division of Vital Records,	sician: The law certificate has l rector, page 2 s	Completed by									24a. Was an autops perform 1 \(\sum \) Yes 2	y ned?	prior to co death? 1 \(\sum \) Yes	psy findings available ompletion of cause of	
/ital	rsician s certifi lirector	To Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☑ No		espital:	patient 2 🗆 I	EB/Outpatien	+ 3 \( \tau_004	TOther:	Death (Chec	k only one) ome 5 ☑ Reside	6	Other (Specif	A	
of \	ing Phy		27. Manner of Death	Pending	28a. Date of		28b. Time of injury		o. Injury at work?		28d. Describe how			<i>9</i>	
sion	Attendir death	Certificate:	2 Accident	Investigation Could not be determined		Injury - At hor		M et, factory,	1  Yes	2 🗌 No	28f. Location (Str.	tion (Street and Number or Rural Route Number,			
Digital in the second of the s															
29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  3 Certifying Nurse Protioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									use(s) and manner stated.						
	within a solution		29b. Signature and title of	certifier	7/100	61	11.		icense numb				signed (Month,		
			30. Name and address of p	person who con	npleted cause	of death (Item	23a) (Type, P	rint)							
	Sto		Garl Sch 31. Date filed (Month, Day,			D. 16		rede	rick	Road	Gaithers	burg	g,Md		
	Stat			0.2010	In log	o olynda	lope	2							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	eartment of Health and N Artificate of Death	, ,	2010	15221				
	Physicia		1. Decedent's Name (First, Middle, Last) Lester James Otto		2. Date of Death Month April 24,		3. Time of Death 7:30 p M				
	Medic Examin		4a. Facility Name (if not institution, give street and number)  Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring		Ic. County of Deat	1				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 390−14−4331 1X M 2 □ F 88 Yrs.		8. Date of Birth June 2, Year	9, Birt	hplace (State or Foreign				
	yland -f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.		•		10d. Inside City Limits				
:	ith the Mar 23a or 28a st be notifi	Funeral Director	Maryland   Montgomery   Kensin   10e. Street and Number   4212 Dresden Street	gton 10f. Zip Code 20895	10g. ( USA	Citizen of What Co	1 ☐ Yes 2 🛂 No untry?				
JU36	De filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at		11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☒ Yes 2 □ No  If Yes, Give WWII era	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ▼ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.				
Maryland 21215-0036	vithin 72 hou jiene. <b>ir than "natu the Medical</b>	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation I kind of work done during most of work DO NOT use retired) es Manager	ing 16b.	Kind of Business	ndustry				
land	d be filed v Aental Hyg arked othe itic event,	To Be	7. Father's Name (First, Middle, Last) Henry Fred Otto  18. Mother's Name (First, Middle, Maiden Surname) Mabel Helen Jung								
, Mar	age 1 and 2 should be file int of Health and Mental I it If item 27 is marked o y or other traumatic eve	8	Henry F. Otto/Son 4212	or Town, State, Zip , MD 2089	· ·						
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1	15	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)	matory or other place)		Location - City or Alexandri					
Ball	Depart Impor any in once,	10	21. Signature of Funeral Service Licensee 5	구심까은 라영 <sup>A</sup> odress 선 5개발ins 00 University Blvd	Funeral Ho	ome Inc. Ver Sprin	g, MD 20901				
- P	h sician/	i b	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Aspiration Pneumo		or respiratory arrest,		Approximate Interval Between Onset and Death 3 weeks				
	Medical Examiner	er	resulting in death)  Due to (or as a consequence of):  Chronic Obstructi Due to (or as a consequence of):	ve Pulmonary Disea	ise		years				
b	and -transit	dical Examine	trans, leading to limite diate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Protein Malnutrit  Due to (or as a consequence of):	ion			months				
00	physician the buria		d. Dementia				years				
BOX 08	In the propriet of Actor and Proposition. The law requires that the clean continuate be executed within 24 hours affected.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown		23d. Date of delivery  Month Day Year						
S, P.O	signed by	by	Part II. Other significant conditions contributing to death but not resulting in the CVA, Adult Failure to Thrive, 60 pa				the cause of death?				
Record	cate has beer	Completed	smoking history	_	24a. Was an autopsy performed?	prior to death?	opsy findings available ompletion of cause of				
VITAI	is certification	To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Checkent 3 DOA Other:	k only one) ome 5 ☐ Residence	6 ☐ Other (Speci	fy)				
on or	eath. or; After th	ertificate:	27. Manner of Death  1	of 28c. Injury at work?  M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred					
DIVISI	urs after de ral Directe	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street a City or Town, Star	te)					
100	thin 24 hour the Fune impleted file	Medical	29a. Certifier (Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or inversion only one)  29b. Signature and title of certifier	stigation, in my opinion, death occurred a	t the time, date and place, and due to the cause	ce, and due to the ce(s) and manner as	ause(s) and manner stated.				
	S+1		Barbara Suparich, 88m, 117	D 0065485		ate signed (Month)					
			30. Name and address of person who completed cause of death (Item 23a) (Type, Barbara Supanich, MD 1500 Forest	Print) Glen Road, Silver	r Spring, N	4D 20910					
	Stat Registra		31. Date filed (Month, Day, Year)  APR 28 2010  32. Registrar's Signature	J							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

ason Pasatiem		1- For State	State of Maryland		rtificate o		and Men	tai riygierie	Reg. N	201	0   522
Physici	an/	1. Decedent's Name (First, N					-	2. Date of Month April 2:	Death		3. Time of Death
ledical Exam	iner	Jason Ray  4a. Facility Name (if not insti	Pasatiempo tution, give street and number	)	— Т	4b. City, Town	, or Location	April 2:	5, 2010	4c. County of Dea	
		University Hospital			l	Baltimor					
Funeral Director		5. Social Security Number 217–19–8525	11K M 2 F	ge (In yrs. I	ast birthday) Yrs		Year If Under Days Hours	Min.		M/DD/YYYY) 9. B Fore	
any		Usual Residence of Deceder 10a. State 10b. Cou		10c. City	Town or Local	tion					10d. Inside City Limits
<b>À</b> . 1	ᅵᅵ	MD P.G.			Co11	lege Pa	rk			1 Yes 2 No	
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 9240 Limest	one Place			10f. Zip Coo 20	<sup>1e</sup> 740			Citizen of What Co	untry?
ath iter	- 1	11. Marital Status 1 X Never Married 2	Married 12. Was Deceden Armed Forces					gin? ( Specify Yes o , Puerto Rican, etc.		14. Race - Ame White, etc.	erican Indian, Black,
s after de ral", or	by F		Divorced if Yes, Give Year or Dates:			Yes 2		kind of work done	1164	Specify: b. Kind of Business	White
72 hour "matu	eted	Elementary/Secondary (0-			during m	nost of working	life. DO NOT	use retired)	- 1		
0036 within 7 iene. er thar	Completed		4		Cryst	al Rep		eveloper			unications
21215-0036  suid be filed within 72 hours after Mental Hygiers, marked other than "natural", ic event, the Medical Examiner.	Be Co	17. Father's Name (First, Mic Danny Pasat					Ju	lia Nolan	1		
MD 21 id 2 should I lith and Mer m 27 is mar	입	19a Informant's Name/Relati Julia Pasati						nber or Rural Route lace, Col			
re, slar flee fritel			ation 3 Removal from S	toto	Place of Dispo- crematory or of tropoli	ther place)		April 3 Y 2010		c. Location - City of lexandria	orTown, State a, Virginia
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other to		4 Donation 5 Othe 21. Signature of Funeral Ser	vice Licensee		500	O Unive	rsity		Sil	ver Spri	ng, MD 20901
Physician //Medical		23a. Part I. Enter the disease failure. List only one ca						ardiac or respirator	y arrest, s	shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disc or condition resulting in dea				complicatio	ns				Dodar
	L.	Sequentially list conditions,	b	e acuence	v0.						
	mine	if any, leading to immediate cause. Enter underlying Ca (Disease or injury that initiat	lusa c.								
B nd uted	ledical Examiner	events resulting in death) L	ast Due to (or as a con:	sequence o	or).						
So, te be executed sysician and burial - transit	dica	UNPENDED	AMENDED				•				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Me	IF FEMALE: 23b. Was decedent pregnant past 12 months?	I LIVO BING!	ome of preg at time of de	2 F	etal death	3 Ectopi	c pregnancy		23d. Date of delive Month	ery Day Year
BO) Le death the att	Physi	1 Yes 2 No 9	Unknown 9 Unknown	4. 5. 4 - 4			una aiuna in Di	ort 23e [	and tobace	co use contribute t	o the cause of death?
P.O. Es that the digned by the		chronic alcoholism	nditions contributing to dea	ith but not i	esulting in the	underlying cat	ise given in Fa		Yes 2		obably 4 V Unknown
ords, P w requires t is been sign should be d	Completed by								Was an autopsy	prior to	autopsy findings available completion of cause of
Reco The lay cate has	M O	4							erformed ∕es 2 ✓		Yes 2 No
ital Redicion: The scertificate rector, page	8	25. Was case referred to me examiner?	Hospital:	ient 2	ER/Outpatien	F	Place of Death Other	(Check only one)  Nursing Home 5	Res	idence 6 Oth	er:
of Vital Records, ing Physician: The law requiring Physician: The law requiring the law requiring the law been a funeral director, page 2 should have the law of the	٦ ا	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, Day		28b. Time of		Injury at Work			injury occurred	
ision Attendii ¤ death. rector: A	atio		Pending Investigation		<u></u>	1	Yes 2	·	(Ct	at and Number or 5	Rural Route Number, City
Division piral or Attendit ours after death, teral Director: A	Certification:		Could not be determined (Specify)	Injury - At r	iome, farm, stre	eet, ractory, on	ice building, e		wn, State		tural Notice Number, Oxy
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifyii	ng Physician: To the best of Examiner:On the basis of ex	my knowled	dge, death occu	urred at the tim ation, in my op	e, date and pl	ace, and due to the	cause(s) date and	and manner as st place, and due to	ated the cause(s)
To the within 7 To the complet	Medical	29b. Signature and title of o	and manner stated	1.			cense number			d. Date signed (M	
5		Theolor	M. Kind JR	, m	· ).	0	.C.M.E.	OCME	A	pril 26, 2010	
		30. Name and address of per Theodore M. King.	erson who completed cause of Jr., MD. Assistant			111 Penr	Street, Ba	altimore, MD 21	1201		
	State	OA Data flad (March Davi)	Foo Desire							·····	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $M_{\text{ay}}^{\text{Month}}$  3,  $20^{10}$  10 Constance L. Russell 013 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 2 / 8 / 1 9 4 2 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Maryland 1 □ M 2 🛛 F 579-84-5718 67 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exercises must be notified at Anne Arundel Annapolis Md XXYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 900 Van Buren St 21403 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ ※ No 14. Race - American Indian 72 hours after 1 ☐ Yes 212 If Yes, Give Year or Dates: ty Never Married 2 ☐ Married Maryland 21215-0036 White 1 □Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "ne N/AElementary/Secondary (0-12) College (1-4or 5+) N/A 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Calvin L Russell Luella I Keyser ! 19a. Informant's Name/Relationship (Type. Print)
Mary Thomas (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any Injury or other traur 2180 Valparaiso Blvd N.Ft Meyer Fl.33917 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 May 12,2010 1 ☐ Burial **XX**cremation 3 ☐ Removal from State Clinton Md Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dunn & Sons 21. Simature of Juneral Service Funeral Home 20019 æ 5635 Eads St NE Wash DC 09 23a. Part 1. Empr the disease shock, or heart failure. L Immediate Cause (final disease or condition resulting in death) se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical or as a consequence of) Examiner Sequentially list conditions, Examiner If u.y, leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Box 68760, attending physician Physician/Medical the use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Duknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 ☐ Yes 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ After this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 1m

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

3

MO

dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

0057635

03, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Richard L. Riggleman, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** Western Maryland Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Days Yrs 74 Keyser, Director 216-32-8244 Tune Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatine avent the state. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Mineral Keyser 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 214 Hughes Street 26726 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Labor Union Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Patrick Riggleman Dorothy Foltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 214 Hughes Street Keyser, WV Margaret E. Riggleman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State May 6 4 Donation 5 Other (Specify) Kevser, WV Potomac Memorial Gardens 22. Name and Address of Facility 21. Signature of Funeral Service I Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ENDOCARDO Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 ding p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other Communications 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury (Month, Day, Year) Netural 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: ⁴
completed filled in by the f Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0025406 ann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Lamm, M.D. 900 Seton Drive 21502 Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25 Day Physician/ Month 04 Marion Rollins Joan 1759 P M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Vicomico KESIONAL 341A SAUSHU4 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 Months Hours 01/12/1932 New York 265-40-9137 78 Director Usual Residence of Decedent 28a-f show aţ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 X Yes 2 No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 21804 141 N. Park Drive USA or items should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2X Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural". white Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) housewife domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Harry S. Cook Marion Trombley 19a. Informant's Name/Relationship (Type, Print)
Bobby W. Rollins/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 141 N. Park Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4 29 2010 Salisbury, MD 21. Signature of Funeral Service Licen <sup>22</sup>Holloway funeral Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Physician. disease or condition resulting in death) Medical Due to (or as consequence of Examiner estites Sequentially list conditions. Examine if any, leading to immediate cause Enter Uncerlying Cause (Disease or iinjury Due to (or as a cons To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Unnary tract and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ g ☐ Unknown detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Sulcide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 068222 04/26/10

Registrar

State

SALISBUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

APR 30

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of M	aryland /		rtment of ⊦ <i>tificate of t</i>		l Mental Hy	ygiene Reg. No 201	0   5226	
	ıysicia Medic		1. Decedent's Name (First, Middle, La Kay Rathgeber	ast)					2. Date of D Month April	Day Yo	3. Time of Death 8:25 a M	
Fur	eral	er		at Riderwood			4b. City, Town, or Silver If Under 1 Year Months Days	Spring	rs. 8. Date of B	4c. County of P.G.	Death  Birthplace (State or Foreign Country)  D • C •	
DAILITIOTE, INTELYIGING ZIZID-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be notified at any once.		To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  3160 Gracefield  11. Marital Status  1X Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las  Mortimer Rathge  19a. Informant's Name/Relationship  Mary Ward/Person  20a. Method of Disposition  1X Burial 2 Cremation 3 I 4 Donation 5 Other (Spec.	12. Was Decedent Armed Forces 1   Yes 2 X If Yes, Give Year or Dates: ducation ade completed)  College (1-4or 2 t)  College (7-4or 2 t)  College (1-4or 2 t)  College (1-4or 2 t)  College (1-4or 2 t)  College (1-4or 2 t)	Pver in U.S. No 15+)	Silv  13. V  14. V  6a. Deced  (Give    iie. L  19b. Mailin  514 1  e of Disposetery, crem  2. Lince	Ver Sprin  10f. Zip Code  Vas Decedent of H Yes, specify Cuba  Yes 251No  ent's Usual Occup kind of work done of NOT use retired  Budget  Arnon Lake sition (Name of latory or other place)	20904  iispanic Origin? an, Mexican, Pur Specify:  ation during most of w  Analyst  18. Mother's N  Florence and Number or te Drive  tee)  etery	10g. Citizen of What USA 10- 14. Race-Black, Specify: 16b. Kind of Busin Federal e, Maiden Surname) 10 ber, City or Town, St. Falls, VA 20c. Location - Cit Brentwoo	at Country?  American Indian, White, etc.  White  ness/Industry  Government  ate, Zip Code)  22066		
Exam	dical niner	dical Examiner	23a. Part 1. Exter the disease, or conshock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Athero: Due to (or a.)  b Due to or a.  c	line.	Do not enter		ng, such as card	liac or respiratory		Approximate Interval Between Onset and Death Years	
the death certific by the attending p	ached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal de at time of deat	eath 3	Ectopic pregnand Other (specify)	y		23d. Date (		
OI VILGI RECORDS, F.O. BOX or Physician: The law requires that the death certificate has been signed by the attending	funeral director, page 2 should be detached for use as	Completed by P	Part II. Other significant conditions Diabetes, Type Hypertension	-	but not resultir	ng in the ur	derlying cause giv	en in Part I.	1 C 24a. Wa aut per	23e. Did tobacco use contribute to the cause of death  1  Yes 2 No 3 Probably 4 Unknow  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause death?		
UIVISION OF VITAL  To the Hospital or Attending Physician; The within 24 hours after death.  To the Funeral Director: After this certificat.	in by the funeral director, pε	Certification: To Be Co	Dementia  25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death  1   Natural   5   Pending investigation investigation of the determined of the control of the	28a. Date of In (Month, D	lay, Year)	28c. Injui	☐Yes 2☐No					
Le Hospital 1 24 hours a	completely filled in by the	Medical Ce	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis fied Nerres	of examination	n and/or in	estigation, in my				ner as stated. d due to the cause(s)	
To the Vithing	dwoo	Me	29b. Signature and title of certifier    Color   Color   Color	Tanille,	CRN	Pa) (Time	29c. Licens  R/2	1686	) Silvar <	29d. Date signed ( 4/27/)  7.19 MI	10	
R	Sta egistra		31. Date filed (Month, Day, Year)  APR 29 20	32 Regis	trar's Signature		Made TIE	ICI NOT.	- 130(1)	P 11 Kg 100	-0/0/	

DHMH 17 Rev 1/2001

		For State	State	of Marylan	•	artment of F			ental Hy	giene	010	5227
		Registrar  1. Decedent's Name (First, Midd.	le, Last)		001	imodic or	Douth		. Date of De			
Physic		Mary Alice Rey	nolds						Month April 27,	Day	Year	5:00 a <sup>M</sup>
/Med Exami		4a. Facility Name (If not institution		number)		4b. City, Town, o	r Location		April 27,		ounty of Death	J 3.00 a
A*		Calvert County	Nursina Cer	nter		Prince Fr	ederio	:k		C	alvert	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days		r 24 Hrs. 8 Min.	Date of Bir (Month, Da	rth		place (State or Foreign
Director		213-44-3134	1 □ M 2 <b>X</b> F		97 Yrs.		1.00.0		June 13			D
and	7	Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
/aryli f sho	ō	,										1 □Yes 2 No
the N	Director	MD Calver 10e. Street and Number	eπ	58	aint Leor	10f. Zip Code			1	10a. Citize	en of What Cou	ntry?
with 3a or			laad							USA		,
Lally Ida I Lall 3-0030 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, I'm Medical Examiner must be notified at	Funeral	6205 Mackall R	12. Was De	cedent Ever in U.	S. 13. \	20685 Was Decedent of Fif Yes, specify Cuba	Hispanic O	rigin? (Speci	fy Yes or No		1. Race - Ameri	
after or ite		1 ☐ Never Married 2 ☐ Mar	ried Armed I	2 X No					can, etc.)		Black, White,	etc.
ours a	by	3 X Widowed 4 □ Divorced	If Yes, 0 Year or			∐Yes 2. No	Specify	<b>/</b> :		5	Specify:	Black
72 hc	Completed	15. Deceder (Specify only highe	nt's Education	4)	16a. Deced	dent's Usual Occup	oation during mo:	st of workina		16b. Kind	d of Business/In	dustry
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led w lygie her ti		6				Ho	usewif		Fi-4 14:44		Home	
be fill half	Be	17. Father's Name (First, Middle,	Last)					ier's Name (i		e, Maiden Si	urname)	
y Ic	은	Walter Graham			1			ence G			- O	
d 2 st d 2 st d 2 st th an th an traur		19a. Informant's Name/Relations				g Address (Street						o Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If frem 27 is marked other than "natural", or frems 23a or 28a-f show or other traumatic event, fru Medical Examinet must be notified at	-	20a. Method of Disposition	eynolds - s			1 Mackall sition (Name of natory or other place		Dat			ation - City or To	own, State
partifications, in permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce.		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 Removal from	n State			i		2040	a		_
partillity permit. Page Department Important: If any injury o		21. Signature of Funeral Service		Bı	OOKS UN	AC Cemete  Name and Addre	ess of Facil					ט
permit. Departitimporta any inju		Haden a	1	P		1451 Dares		Sewe	ell Funer			7 <u>8</u>
		23a. Part 1. Enter the disease, o	r complications that	t caused the deat							, IVID 200	Approximate Interval Between
Physician		shock, or heart failure. List Immediate Cause (Final				Carrol	letari	0000	lms	dire	in ca	Onset and Death
/ /Medical		disease or condition resulting in death)		eroscie o (or as a conseq		Cayo	JOV	CA CEL	Ren	cuse	axe	
Examiner			. Hy	morte	ncive	Hec	an i	os cui	"seces	0		
P +	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o or as a conseq	-							
ecute ind transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
cate be executed obysician and the burial-transit		resulting in death) Last	Due to	o (or as a conseq	uence of):							
	dical		d								-	
eath certific attending p	/Me	IF FEMALE:	23c If yes o	utcome of pregna	ency							
atten for us	sian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	e birth 2 🗌 Feta	ldeath 3□	Ectopic pregnanc	су			23	Bd. Date of deliv Month	very Day Year
ires that the designed by the a	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										
that		Part II. Other significant conditi	ons contributing to	death but not res	ulting in the ur	nderlying cause giv	en in Part	l.	23e. Did	tobacco use	e contribute to 1	the cause of death?
quires n sign	d by	Acute or	chro	onie F	Renal	fceilu	UZO		1 🗆	Yes 2□	No 3 ☐ Pro	bably 4 🗹 Unknown
w requir	lete	Consestiv	P HA	cont	FCeil	. m 0			24a. Was	an	24b, Were auto	opsy findings available
The lay te has age 2	Completed		<u> </u>	2011	1000	w <u>~</u>				ormed?	death?	opsy findings available ompletion of cause of
Attending Physician: The law requires that the death certific rideath.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Be C	25. Was case referred to medica	l l				26. Plac	e of Death (	1 ☐ Yes Check only	2 ☑No one)	1 ☐ Yes	2 LIN0
ysici is cer	To B	examiner? 1 ☐ Yes 2 🗹 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Oth					☐ Other (Speci	ifv)
ig Ph ter th	i.	27. Manner of Death		te of Injury onth, Day, Year)	28b. Time of Injury	28c. Injur Wor	ry at		d. Describe			
ath.	atic	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	man, Duj, rour,	,,		Yes 2□	]No				
r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be nined 28e. Plac buil	ce of Injury - At holding, etc. (Specif	ome, farm, stre	eet, factory, office		28		(Street and wn, State)	Number or Rur	al Route Number,
rs aff	Ser							. 4				
To the Hospital or Attending lwithin 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examina	wledge, death tion and/or in	n occurred at the ti vestigation, in my o	ime, date a opinion, de	and place, areath occurred	d due to the at the time	e cause(s) a , date and p	and manner as place, and due t	stated. to the cause(s)
the the the the the the the the the	Med	one) 29b. Signature and title of certifie		anner stated.		29c, Licens	o numbor			20d Date	signed (Month,	Day Vaarl
<b>6</b> 월 <b>6</b> 일		250. Signature and tipe of certifie	n.c.	Survey	10			653			- 27-	-
		7							1220.0		~ /	
ero 6		30. Name and address of person $5851$ -	Deale	Chu	nch H	EN BY	12.	Dea	URA	W D	207	5-1
St	ate	31. Date filed (Month, Day, Year)	Deale R 29 2010	Registra s Signa	ture		7		1	111		
Regist	rar	API	x 29 2010	Denver	U A.	parket	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	r lease Type of Fillit in black
Giovanny Francisco Reyes	State of Maryland / De

iovanny Franc	isco	Reyes S 1- For State Registrar	tate of Maryla		artment of rtificate of		d Mental H		eg. No. 20	10 15228
Physici Medical Exam		1. Decedent's Name (First, Mid	Francis	co R	eyes			2. Date of Dear Month April 23, 2	th Day Year	3. Time of Death 1723 hrs
		4a. Facility Name (if not institut Holy Cross Hospital	ion, give street and nu	mber)		b. City, Town, or Silver Spring			4c. County o Montgorr	
Funeral Director		5. Social Security Number 215-33-2992	6. Sex 1XM 2F	7. Age (In yrs. I	last birthday) Yrs	If Under 1 Year Months Days				9. Birthplace (State or Foreign Country) Wash., D.C.
w any		Usual Residence of Decedent  10a. State 10b. County  MD Mont	gomery		, Town or Locati	on Spring				10d. Inside City Limits 1 Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 10414 Hemle				10f. Zip Code 2090	12	10	Og. Citizen of Wha	at Country?
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ral Examiner must be notified at once	Funeral D	11. Marital Status  1 X Never Married 2	12. Was Dec	edent Ever in U		s Decedent of Hisp es, specify Cuban,	panic Origin? ( S Mexican, Puerto	Rican, etc.)	- 14. Race - White,	- American Indian, Black, etc.
nours after d natural", or	þ	15. Decedent's Education (Sp	vorced If Yes, Give Year or Dates: ecify only highest grad	r le completed)	16a. Deceden	Yes 2 No	on (Give kind of		Specify:	ite
1215-0036 Id be filed within 72 hours aftr fental Hygiene. parked other than "natural" event, the Medical Examine	Completed	Elementary/Secondary (0-12 1 1 1		-4 or 5+)	_	Student Hic				school
MD 21215-0036 d 2 should be filed within 7.7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medical	To Be C	17. Father's Name (First, Middle, Last)  Giovanny T. Reyes  18. Mother's Name (First, Middle, Maiden Sum Esperanza E. Flori  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or							.Flores	
e, MC and 2 s fealth ar item 27 traums		Giovanny T.R		20b. I	104	14 Heml	ey Lan		er Spri	ng, Md 20902 City or Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr		1 Burial 2 Crematic 4 Donation 5 Other S 21. Sig to 0 e of Funeral Service	Specify:	on otate	ate of	Heaven				er Spring,Md
m ឧក្គាធិ Physician	4.1	23a. Part I. Ent. the disease, of failure. List only one caus.	r complications that ca	aused the death.	92 Do not enter th	41 Colu	RINALD Imbia B such as cardiac c	1 FUNE 1vd.Si or respiratory arre	RAL SER $lver$ $Sp$ est, shock, or hear	
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	<sub>a.</sub> Asphyxia by	/ hanging	f):					Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		consequence of						
e executed cian and riral - transit	Exa	events resulting in death) Last	c	consequence of	f):		_			16
oe e icia	n/Medical	IF FEMALE: 23b. Was decedent pregnant in the	AMENDED  23c. If yes, c	outcome of pregr		al death 3	Ectopic pregna	incv	23d. Date of d	elivery Day Year
Box 68760, re death certificate by the attending physical for use as the but	Physician/Me		4 Pregna 9 Unkno	ant at time of de wn	ath 5 Oth	er (Specify)			Month	Day real
P.O.	ð	Part II. Other significant condi	tions contributing to	death but not re	esulting in the u	nderlying cause giv	ven in Part I.	1 Yes	2 <b>✓</b> No 3	
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed	<u> </u>						24a. Was a autops perform	sy pri med? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital Rec hysician: The rthis certificate	To Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Ir		ER/Outpatient	3 DOA			Residence 6	Other:
Sion of Attending P death. ctor: After vy the funera			ding Stigation 28a. Date of (Month): Apr 23, 2	Day,Year)	28b. Time of In FOUND: 1630 hrs	1 Ye	es 2 V No	Subject hang		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	4 Homicide dete	ermined (Specify)	residence		, factory, office bu		or Town, St 10414 Hemley	ate) Iane, Silver Spi	
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only	hysician: To the best iminer:On the basis o and manner sta er	f examination ar	ge, death occurr	ed at the time, date on, in my opinion, 29c. License	death occurred a	due to the cause t the time, date a	nd place, and due	s stated. e to the cause(s)
2		lelin	NI	of death lite	2327	O.C.M			April 24, 201	
			Assistant Medica		111 Penr	Street, Baltin	nore, MD 21	201		
St Regist	ate trar	31. Date filed (Howh, Day Year)	010 Jenen	north a Signatur	re park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Year **Physician** Delmer Richardson Charles 28,2010 0020 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Micomico RehabaN ursingCta Shuru If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. Birthplace (State or Foreign Country) **Funeral** Days Min. Months 1 XM 2 ☐ F 214-32-0766 75 Director 02/04/1935 Virginia Usual Residence of Decedent 10d, Inside City Limits 10h County 10c. City, Town or Location 10a. State ?] is marked other than "natural", or items 23a or 28a-f show traumatic event, Ihe Medical Examiner must be notified at 1 □Yes 2 XNo Director Wicomico Salisbury harles Richairdson timore, Maryland 21215-0036 Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number LISA 21804 4480 Chicken Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 [3]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 XNo 1∐Yes 2. ANo Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Messes once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) poultry poultry grower 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta Marie Miller Charlie Elmer Richardson ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4480 Chicken Lane, Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print)
Madeline Mae Richardson/spouse 20b. Place of Disposition (Name of cemetery, ciematory, or other place Springhill Memory Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 30 2010 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) HOTTOWAY FUNETAL Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 Association >CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final **Physician** Kecen sardisease or condition resulting in death) /Medical to (or as a consequence of): Examiner TON. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Records. P.O. Box 68760. attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 des 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerform certificate 2 🗆 No 2 No 1 🗆 Yes 1 □ Yes Division of Vital 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sbury lliam H. 31. Date filed (Month, Day, Year) 32. Fegistrar's Signatu State APR 30 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 2010 9:45 a. Nettie Mae Sloan April 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6, Sex Age (In yrs. last birthday) Days 1 🗆 M 2 🖾 F Months March 17,1920 Hours Washington D.C. 90 578-18-3190 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 903 McLendon Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🛛 No 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Arthur Sengstack Viola Dipple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18085 Holly Drive, St. Inigoes, Maryland 20684 Robert C. Sloan Jr/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery May 3,2010 Suitland, Maryland 22. Name and Address of Facility. Stauffer Funeral Homes P. A. 21. Signature Funeral Service Lies 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ob each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 A No 3 Ectopic pregnancy 5 Other (specify) Month Year Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 1 Yes 2 L

Ph sician/ Medical Examiner

Physician/

Medical

10a. State

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

28a-f shov

ral", or items 23a or 28a-f sho Examiner must be notified at

72 hours after

1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exal

Page 1 Department of Important: If it any injury or o o =

Baltimore, Maryland 21215-0036

page 2

Examir

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Certificate:

Medical

only one 29b. Signature

IF FEMALE

attending physician and for use as the burial-tran ed by the detached signed b been signature Jas certificate To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors.

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
Engly	lema	1 🗆 Yes 2 🗀 No 3 🗀 Probably 4 🗀 Unknown							
U 1		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No							
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1  Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death  1 Natural 5 Pending 20 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury injury  28c. Injury at work?  1 □ Yes 2 □ No	Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not I determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)							
	rsician: To the best of my knowledge, death occured at the time, date and place, and d								

3 Certifying Nance Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D14285

29d. Date signed (Month, Day, Year)

20

State Registrar

30. Name and address of person who completed lause of death (Item 23a) (Type, Print) William D. Boyd, II

29

31 Date filed (Month, Day, Year)

nd title of certifier

M.D. 32. Registrar's Signature

25365 Point Lookout Rd., Leonardtown, MD 20650

10-03472 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tracy Williams State of Maryland / Department of Health and Mental Hygiene Amend #22-For State FH. TCHD. P Avers 5/16 Prificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Tracy Williams 2. Date of Death Physician/ Medical Examiner JoAnne Smith-Williams 0445 hrs May 5, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 803 Church Street Cambridge Dorchester 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral 240-23-9338 Months Days Director Hours Min 1 M 2 F 48 03/20/1962 Country) Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge 1 Yes 2 No or 28a-f show "natural", or items 23a or 28a-f sho hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Church St 21613 USA Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 2 X No Yes 3 Widowed White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: is marked other than "natural", ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 hert of Health and Mental Hygiene. College (1-4 or 5+) timore, MD 21215-0036 12 1 Administrative Assistant Medical 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Jo Ann Cornelison Hal W. Smith II 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 h Nicole Williams (daughter) 5023 River Rd Hurlock, MD 21643 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Direct Crematory 05/10/10 Dover, Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD. Bennie Smith FH 516 S. Main St Hurlock, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line 8etween Onset and /Medical Death a Mixed drug (Citalopram, desipramine, fentanyl, tramado Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical X UNPENDED physician the burial AMENDED Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. 27,28a-f,per ME G904 6/8/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 V Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural 1 Yes 2 X No Pending Director: Fd 5/5/10 Fd 4:30 am 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or, Town, State) 003 Church St Cambridge, MD To the Hospital or A within 24 hours after 3 Suicide 6 X Could not be determined residence To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

Carol Allan, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OGME

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 5, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ment **Physician** ISAR BARA DOATH 12:45 R 28 O /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MAYIUN Care BALTIMOR UNSON OWSON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ XF Months Days Hours Yrs March 1, Director 1933 Virginia 214-30-0545 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner nast be notified at 1 Yes 2 □ No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō itеms 23a 24 Hillside Ct. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cament of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten
ury or other traumatic event, I'm Michol Exprime 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Tho Specify **S** Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Carroll County Elementary/Secondary (0-12) College (1-4or 5+) Health Department 8 Nursing Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked or any Injury or other traumatic eve once. ဥ Ruby Cornelia Iong Livingston Hansbrough Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Hillside Ct. William B. Suddath Husband Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Inc 4/29/2010 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitPritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 23a. Parta. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ari) io pulmmary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, from the Little Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate ba executed physician and the burial-transit decubiti Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical GEMENTIA attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Year Month 5 Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypothyroid 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HBP 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy Hyperchalesterlemia certificate 2 No 1 □Yes 1 TYes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

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filled in by the funeral dire Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a **To the Funeral C**completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of portifier 2

State

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31. Date filed (Month, Day, Year)

ame and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

29d. Date signed (Month, Day, Year)

29c. License number

JOPPA RUPD

Towson, MD. 21286

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Blaine DINES JI LLIAM 7:40<sup>PM</sup> April 30, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1050 Bishop Walsh Road Cumberland Allegany 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Country)
Maryland Months Days Hours Min. 12 M 2□ F 218-20-2326 Director November 10, 1926 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifled at 1 Yes 2 No Director Maryland Allegany Cumberland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1050 Bishop Walsh Road 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: 3 Nidowed 4 Divorced Year or Dates: White Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatic event. the Mea Elementary/Secondary (0-12) College (1-4or 5+) Stationary Steam Engineer University 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Silas Sines, Sr. Gladys Marie Sines 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Sines - Son 13101 Gramlich Road, LaVale, Maryland, 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 08. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Taylor-Sines Cemetery** Oakland, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 15000 oli William 8 East Main Street Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) × RJ Physician ARKINSON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by PARKINSONS DEMENTIA aF 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 14 UPERTONSTON 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performe SACK this certificate CITYONIC within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ YeNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature apaytitle of certifier 29d. Date signed (Month, Day, Year) 4205 5 2010

DHMH 17 Rev 1/2001

State

Registrar

Camberland Muland

Sotor Drive

32. Registrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

2010

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03: 27A M 04 2010 OVVO. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salisbury Hospice at the Wicomico -oastal 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 DOF 91 Hours Min. J(Month, Day, 318-09-0588 Director Usual Residence of Decedent Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral q USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Seconday (0-12) College (1-4 or 5+) Own 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Chene Jennie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RisingSun MD 2191 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 5,2010 Orlando 4X Donation 5 ☐ Other (Specify) 21. Signature Funeral Pervice License 22. Name and Address of Facility C+A Removal Services Chipmunk hane, Clearbrook M01080 mwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Cardiovascular Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year ed by the a P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 PNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 6 Other (Specify) ASSTD. LIV 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Peath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending Investigation 6 Could not be 1 🗌 Yes 2 🗌 No Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0058410 4/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-7 MAY 0 3 31. Date filed (Month, Day, 32 Registrar's Signatu State 2010 Registrar

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	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Birthplace (State or Foreign		
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	sryla shov	<u>_</u>	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ■ No	
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	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - Black.	American Indian, White, etc.	
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DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 11:50 p M Stanley Leroy SOCKS 2010 30, April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 703 Maryland Avenue Washington Hagerstown 8. Date of Birth (Month, Day, Nov. 2, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1944 Months Days Hours Mary Land 219-44-4424 65 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 1∩a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a 703 Maryland Avenue 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1968- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify <u>Ş</u> white 3 ☐ Widowed 4 K Divorced 1970 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) truck driver concrete company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Edward Socks Freda Ruth Wentling ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Carol Socks - ex-wife 703 Maryland Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hagerstown Crematory 5/3/2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** gastrointestina months disease or condition resulting in death) \* /Medical ue to (or as a consequence of) Examiner of the CITTHOSIS Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Probably 4 Unknown page 2 should Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The I
 24 hours after death.
 Funeral Director: After this certificate by 1 ☐ Yes 2 ☐ No 1 □ Yes 2 WNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47451 May 3, 2010 Cynthea Kuther Sands no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Cynthia Kuther-Sands MD Hospice of Washington County, 747 Northern Avenue 3H 5+1 Hagerstown, Maryland 21742 31. Date filed (Month, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Smith Kathleen Flynn A Thil 196, 20 1°0 3:30рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Fox Chase Nursing Home Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 93 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours 502-07-9000 1 □ M 2 😾 F Month, Pay, Year) 7 North Dakota Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any higury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 2015 East West Highway 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction/ Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Co. Accountant 12 17. Father's Name (First, Middle, Last)
Flynn Be 18. Mother's Name (First, Middle, Malden Surname) 2 unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20006 19a. Informant's Name/Relationship (Type, Print) 1700 Pennsylvania Ave.N.W.#600 Wash.,D.C. Patrick Smith/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4/24/2010 Silver Spring, Md Gate of Heaven 5 Other (Specify) 4 Donation 21. Signatur PHINTIP ANDESTINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the c shock, or heart fa sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Dementia-advanced Cnysician/ disease or condition бию. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 2 XNo page 2 should be detached 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown diabetes mellitus, hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

I Director: After this certificate has I d in by the funeral director, page 2 s 1 Yes 2 No 2 XNC Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X**No Hospital: Other: 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No XNatural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 🔎 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 23,2010 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Registrar's Signature

15225 Shady Grove Road Rockville, Md. 20850

Passi M.D.

Day, Year)

28

Ravi

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 35 20010 Pauline Reese Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oct 28 1917 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Min. 1 M 2 92 Marvland Director 217-12-1334 Usual Residence of Decedent show items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Boonsboro Maryland | Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8507 Mapleville Road 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc ō 1 Never Married 2 Married ☐ Yes 2 ■ No Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify. Specify: White "natural" 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 8 Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Page 1 and 2 should be Mary Spessard Reese Albert Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Linden Road, Middletown, MD 21769 Ann M. Keyfauver/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State o Cemetery May 7,2010 Boonsboro, Maryland 22. Name and Address of FacilityBast-Stauffer Funeral Home P.A. 4 Donation 5 Other (Specify) Boonsboro Cemetery er I Service 21. Signature of F 7606 Old National Pike, Boonsboro, MD 21713 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest conly one cause on each line. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any heading to immediat cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician I for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy sate has been signed by the atte page 2 should be detached for in the past 12 months? Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, 5 Pending Natural 1 Tes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature ar title of certifie 29c. License number 30. Name and a

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Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ April Mary Jane Testa 27. 4:15 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice-Casey House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏲 F 236-98-3110 51 Months Days Hours Min. Sept. 5, Year 1958 West Virginia Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14622 Sandy Ridge Road 20905 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 🔽 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 xxNo Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benny Joseph Testa ၉ Ruth Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14622 Sandy Ridge Road, Silver Spring, MD 20905 George B. Fultz/Husband Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beverly Hills Memorial 20a. Method of Disposition Date 🗚 Burial 2 🗌 Cremation 3 🛚 Removal from State  $May_0^1$ , 4 Donation 5 Other (Specify) Morgantown, WV 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 X No 4 ☐ Pregnant 9 ☐ Unknown ate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an after death.

Director: After this certificate has autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 St Other (Specify) Hospice 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the

State

Registrar

29b. Signature and title of certifier

APR

Bindu Joseph, MD 31. Date filed (Month, Day, Year)

90

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1355 Piccard Drive, #100, Rockville, MD 20850

D60634

29d. Date signed (Month, Day, Year) April 27, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ April Teske 23 Stephen Ronald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Solomons Island Road Lothian If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Months Days Hours Min. 1272871971 New Jersey 451-89-9079 38 Director Usual Residence of Decedent items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1 □ Yes 2 🛣 No MD Anne Arundel Lothian 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral U.S.A. 5234 Solomons Island Road 20711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: Specify. 3 Widowed 4 Divorced white Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) church clergy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Ronald Ernest Teske Judith Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5234 Solomons Island Road, Lothian, MD Janet Ann Teske, wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dunkirk, MD Memorial Gardens | 04/29/2010 | 22. Name and Address of Facility Rausch Funeral Home, P.A. Funeral Service Lice 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MUNTH Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed? Yes 2 1 Yes 2 No Be ( 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ⚠ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 
Natural 5 Pending Jubject 4/20 UNKM 1 Tes 2 No Accident Investigation 110 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide determined building, etc. (Specify) OTHIAN Hospital within 24 hours To the Funeral Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

eputy

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ones

32. Registra s Signature

06054

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April <sup>Day</sup>2010 Hilary Teodorescu 12:56 A.M 23 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery 4b. City, Town, or Location of Death Examiner Silver Spring Holy Cross Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Y Aug. 16 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Davs Hours 577-52-7782 87 Director 1922 UNITED Kingdom Usual Residence of Decedent or 28a-f show notified at e filed within 72 hours after death with the Maryland ttal Hygiene. do do do do do do do do do do ther than 'natural", or items 23a or 28a-f showed of other than 'naturals', or items 15e notified at event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3124 Gracefield Road 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes : If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Public Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n and Mental H 7 is marked o မ .. Page 1 and 2 should be it trent of Health and Ments tant: If item 27 is marked jury or other traumatic e Frederick Millar Dorothy Ann Aldred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1100 Cavendish Drive, Silver Spring, MD 20905 Anna Wolfe/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Georgetown University
Medical Center 1 
Burial 2 Cremation 3 Removal from State April 24 4 😾 Donation 5 🗌 Other (Specify) Washington, D.C. 2010 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licenses /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an has autopsy performed? After this certificate Yes 2 V No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. neral Director: After this d filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🗙 Natural work? 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 29a Certifier To the Hosp within 24 hor To the Funer completed fil t Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59524 April 23, 2010 thumane Ullu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road

State Registrar Loveen

31. Date filed (Month, Day, Year) APR 28 2010

J.

Silver Spring, MD 20904

Puthumana, M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lintamova omluck 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Grove Shady Adventi Montanneva HOSD. Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept, 12 g. Birthplace (State or Foreign Country) Thailand **Funeral** Days Hours 579-04-6786 Director 71 Yrs 1938 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Types 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 Rollins Ave # 418 20852 Thailand 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. "natural", 3 Widowed 4 K Divorced Specify: Completed Asian traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housemaid Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sangaun Chanvijit Naree Banlengjit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Maleewan Chinaprayoon/None Thai Embassy 1024 Wisconsin Ave NW, Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 4/30/10 4 Donation 5 Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee M01463 <u>1040 Rockville</u> Pike. Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ancer +a disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and is the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3. Ectopic pregnancy in the past 12 months? ☐ Pregnant at time of death☐ Unknown 5 Other (specify) Dav Year been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1. Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. Ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1-Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State within 24 hours a To the Funeral L To the Hospital Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier on who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Medica

9901

62. Registrar's Signature

Day, Yea

2010

Center Drive, Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Clarence Eldred Valentine April 30, 2010 6:18<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 □ F Months 213-18-8589 Director December 23, 192 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, in which of the control of the contr Director 1 K Yes 2 □ No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 66 West Main Street 21539 by Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Black, White, etc 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. 12 Principal Education 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Sylvester Valentine Virginia Miller 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Eleanor Valentine - Wife 66 West Main Street, Lonaconing, Maryland, 21539 Date May 04 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any injury or 1 ■ Burial 2 □ Cremation 3 □ Removal from State Frostburg Memorial Park 2010 Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Brandi Wuhalm 8 East Main Street Lonaconing, MD 21539 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CONCESTIVE /Medical Due to (or as a consequence of): Examiner CORDNARY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit the death certificate be executed Due to (or as a consequence of) O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 ☐ Unknown ۵. The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Lirector A completely filled in by the fu death. 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide

State Registrar

Medical

5

29a. Certifier

29b. Signature and title of certifier

31. Date-filed (Month, Day,

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

026907

925 Rishoo Walsh Rood, Cumber and Monyland
132 Registral Signature

29d. Date signed (Month, Day, Year)

2010

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 May 8:00 рм <u>Thomas Franklin Waters</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 10322 Old Liberty Road If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours September 26 Country Maryland 62 217-58-2819 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🗓 No Maryland Frederick Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21701 United States 10322 Old Liberty Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, the once. Dance Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dora Viola Payne Floyd Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10322 Old Liberty Road, Frederick, Maryland 21701 / Wife Karen Waters 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State May 13, 2010 Frederick, Maryland John's Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Keeney and Basford PA Funeral Home 106 East Church Street, Frederick, MO1473 Maryland 21701 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death
Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Alzheimer's Disease Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 X No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 **X**) No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 7

29b. Signature and title of certifier

Joseph Ashwal, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

56 Thomas Johnson Drive, Suite 200, Frederick, Maryland 21702

29d. Date signed (Month, Day, Year) May 10, 2010

29c. License number

D26609

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ White 27 2010 April 4:55  $\mathbf{A}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING AND REHABILITATION CENTER WORCESTER BERLIN 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔣 F 0876841924 Maryland 220-12-5837 85 Director Usual Residence of Decedent or 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1135 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or i Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: white Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife domestic and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank P. Williamson Emma (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sue Ann Bell/daughter 3 Blue Heron Circle, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 D Burial 2 A Cremation 3 D Removal from State 4/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Lice 222 Hangland Address Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Alzheimer's Dementia Medical resulting in death) **Examiner** Aspiration pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 1 Tes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Tes 2 No Yes 2 XN 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ 1 🗌 Yes 2 🗆 **X**Io ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🔲 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. orthroi \*\*Certifying Nurse Practioner 10 the best of my knowledge, Settle proposed at the time, data and place, and due to the 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) April 27, 2010

Registrar

Pennie

DHMH 17 Rev 7/2009

and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Savage,

R135131

9715 Healthway Dr, Berlin, MD

21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ralph Woel April 27, Day 2010 Year 2:05 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 1002 Gabel Street Silver Spring Birthplace (State or Foreign Country)
 Haiti Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** Hours 117-30-8034 Dec. 29, Year) 1933 76 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🌁 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1002 Gabel Street 20901 USA and Mental Hygiene.
is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 😾 Married ☐ Yes 2 🙀 No Maryland 21215-0036 Specify: White 1 ☐ Yes 2XX No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Own Business Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lina Martineau Gaston Woel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda E. Woel/Wife 1002 Gabel Street, Silver Spring, MD 20901 Baltimore, 20a. Method of Disposition
1 Durial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or Silver Spring, Maryland Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Ph\_sician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Kidney Failure Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of, ysician and e burial-transit e Hospital or Attending Physician: The law requires that the death certificate be executed 3.2 butours after death.

12 butours after death.

12 butous after death.

13 certificate has been signed by the attending physician and bieted filled in by the futnerial director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the I

comple only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ester D55679 April 28, 2010

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR

29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Devika S. Wijesekera, MD 12201 Plum Orchard Drive, Silver Spring, MD 20904

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 27, 2010 Williams 12:15P M Joyce Ann Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14055 Pellita Terrace Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🔀 Days (Month, Day, Year, 2-27-44 66 Director Wash. DC 579-56-6838 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville XYes 2 No MD. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 14055 Pellita Terrace U.S.A. death \ 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Computer Specialist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel John Williams Pearl Lee Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deadrid Brown/Neice Pellita Terr., Rockville, Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other pla@em 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5/1/10 Woodford, Va. St John Bapt Ch 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur, of Funeral Service Licensee 2 Name and Address of Facility Hackett's Funeral Chapel, 814- Upshur Street, NW D Inc. C. 20011 W Hacket art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed -tran and resulting in death) Last Due to (or as a consequence of): bunial physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Day Vear Pregnant at time of death Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsv performed? Yes Physician: director, Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending ithin 24 hours after death.

the Funeral Director; Asympleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

State

within 2 To the F

Medical

4 Homicide

29a. Certifier

(Check

29b. Signature and title of certifier

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31. Date filed (Month, Day, Year)

determined

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

City or Town, State)

29d. Date signed (Month; Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Jean T. Williams Month Day Year Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Wicomico Examiner 4b. City, Town, or Location of Death Coastal Hospice at the Lake Salisbury If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 79 Months Hours Min 14976 Py 1930 207-20-6830 Director PA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director or 28a-f Worcester Ocean City 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 14501 Tunnell Ave., Unit 105 Wanamar 21842 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 of Health and Mental Hygiene. "natural", item 27 is marked other than "natural", other traumatic event, the Medical Exal If Yes, Give 1 ☐ Yes 2 😾 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Loretta Ruffo Nicholas Travaglini ည permit. Page 1 and 2 should Department of Health and M Important: If item 27 is may any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Williams 930 Caravan Trail, Owings, MD 20736 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 04/28/2010 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens de Lisa M Mounts 22. Name and Address of FacilityLee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ANCRRA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Pregnant at time of death Other (specify) Year ed by the a detached f 4 ☐ Pregnant a 9 ☐ Unknown signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires twithin 24 hours after death.
To the Funeral Director: After this certificate has been sign 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed iis certificate has been si director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 🗂 Natural iniury 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registra s Signature

1733 SAWBBURY WO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 13<sup>3</sup> 20 ได้ 7:15A M Thomas Michael Abitabilo, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Howard Brighton Gardens of Columbia Columbia Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛣 M 2 🗆 F Months Days Hours 10-6-1915 Year) New York 081-05-1503 Director 94 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 🎛 No Columbia Howard Maryland 1 4 1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21044 10358 Windstream Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married ģ If Yes. Give 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pasquelina Annunziata Neil Abitabilo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10358 Windstream Drive Columbia, Maryland 21044 Patricia Latteri (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State 5-17-2010 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 4 Years shock, or heart failure. List Immediate Cause (Final Alzheimer's Disease ₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 Urknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Assisted Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Spec 2 🔀 No 1 Yes မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA ivine this 28a. Date of injury (Month, Day, Year) within 24 hours after deau..

To the Funeral Director: After thi funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) M.D. D56531 May 13, 2010

Registrar

State

DHMH 17 Rev 7/2009

Dr. Harry Li 8600 Snowden River Parkway #301 Columbia, Maryland 21045

32. Regis ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAY 1

Amend #1, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene / | | For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4<sup>Day</sup> Physician/ May Month 2010 2345 <del>- Ann - Archer</del> Susan Anne Archer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 01ney 19133 Willow Grove Road Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min July 3. 1 🗆 M 2 🛛 F Washington, D.C. 224-54-4806 T940 Director 69 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 X No Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19133 Willow Grove Road 20832 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No 1 Tes 2 No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mark A. Heck Marian A. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Mark Archer / Son Brassie Court, Montgomery Village, Maryland 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 9 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 Donation 5 Other (Specify) 2010 21. Signatura of Funeral Service Lice Robert A. Pumphrey Funeral Home/Rockville, Inc. Hoven M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DME Immediate Cause (Final Physician/ Probable Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b, Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 💹 No Month Day Year the 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury work? 1 ☐ Yes 2 ☐ No 5 Pending Nithin 24 hours after death.

To the Funeral Director: Aft Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif, 29c. License number 29d. Date signed (Month, Day, Year) mp DMG D00428 May 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira N. Brecher, MD DME, 524 Hawkesbury Lane, Silver Spring, Maryland 20904 31. Date filed (Month 32. Registrar's Signature State parker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BROWN FRANCES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death Howard 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Director Usual Residence of Decedent or 28a-f show should be filed within 1/2 row...
and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21200 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Black Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) onday (0-12) College (1-4 or 5+) General dtr Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Brown - daughter WOODLAWA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicensee 23a. Part 1. Enter the disease, or complications that values shock, or heart failure. List only one cause on each line. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death o bs tructum Immediate Cause (Final bowel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ardio Vasculer Di Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy 5 Other (specify) in the past 12 month Month Dav Year ate has been signed by the a page 2 should be detached in g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 onknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: ည 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 2 🗀 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ( James 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rawy Sabapally 201-109 Kack PWW Meck Road Balkmu Majlw 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Butles 8.12 A M Sylva 0 5 10 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA more 205 If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 M 2 7 Months Director an Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be redilled at 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip 10g. Citizen of What Country? US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: ş 3 Widowed 4 Divorced Department of Health and Mental Hygiene. "natural", important: If tem 27 is marked other than "natural", any injury or other traumatic event, It who ical Expose. Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary, (0-12) College (1-4or 5<sub>₹</sub>) a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Edward mal 105 Shrewsburs Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 7-2010 Com 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Nancy m. Wallace 23a. Part | Enter #1e di lease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, if leart from the cause on each line. Approximate Interval Between Onset and Death Physician Confirm disease or condition resulting in death) /Medical Due to (or as a Ansequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Diasete burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 ☐ Probably 4 ☐ ₩hknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h 2 No 1 □Yes 2 <del>- N</del>o 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 1400 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MD D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31

State 31. Date filed (Month, Day, Year)
Registrar

2010 Shows S. Janes Shitt 308, BALTIMORE MID 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Gordon Charles Beckman 2010 9:15pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3455 E. Ivory Road West Friendship Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign July 4, 1918 1 🕅 M 2 🗆 F Hours 496-10-1171 Country) 91 Director Yrs. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Howard 1 🗆 Yes 2 🔽 No West Friendship 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3455 E. Ivory Road 21794 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced WWII White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Printing Office Emplyee Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Charles Emil Beckman Blomberg Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or when Mrs. Lela May Beckman (Spouse) 3455 E. Ivory Road, West Friendship, MD 21794 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 5/17/10 All County Cremation 4 Donation 5 Other (Specify) Sykesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA MO0764 PO Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ alure disease or condition Medical resulting in death) or as a consequence of) **Examiner** eers Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit adder Due to (or as a consequence of) resulting in death) Last -burialpeers physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 Pregnant
9 Unknown Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No page certificate 1 🗌 Yes 2 🗆 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending iniury work? 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifi-

31. Date filed (Month, Day, Year)

Knoll

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Soute

29c. License number D0031927

17, 2010

min 21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 2:45  $A^{M}$ Matilda L. Bell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2XXF October 25, 1918 Hours 217-05-7256 91 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 No **Paltimore** Carney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 9614 10th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify If Yes, Give Year or Dates White 3XX Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 | and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Admin. Claims Processor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury exercity. ည Agnes Hessian John Bathqate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9614 10th Avenue, Carney, Maryland 21234 Linda Barker - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Fvans Funeral Chapel and
Cremation Services—Bel Air 1 🗌 Burial 2 🗶 Cremation 3 🗆 Removal from State 15, May 1: 2010 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Reed Parkville Maryland 2123/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequedce of) Examin that the death certificate be executed ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ò Day Pregnant at time of death signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy 2 No certificate Yes 2 XNo 1 Yes **Division of Vital** 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Funeral Director: After completed filled in by the funer 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending 1 Yes 2 No hours after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) Kaller 60 Lo el 32. Registrar's Signature State

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month May Mildred Morris Barnes Pay 2010 12:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In ars. last birthday) 9. Birthplace (State or Foreign **Funeral** 258-28-7983 July 15, 1922 1 M 2 K F 87 Yrs. Georgia Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Tes 2XXNo Georgia Gwinnett Duluth 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 4763 Bogie Road 30096 of America or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2XX No If Yes, Give Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home and Mental Hygie is marked other Be and 2 should be filed and Health and Mental Hw Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hamilton Morris Dora Lee Richards injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Karen B. Visser/ daughter 1716 Killington Road Towson, Maryland 21204 timore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel 1 Burial 2XXCremation 3 Removal from State May Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 21. Signature of Funeral Service Ligensee 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between disease Onset and Death? Immediate Cause (Final SIAG Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 ttending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day 2 1 No ed by the detached f a \ Unknown 9 Unknown s been signed by the Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Jailine, Vocal cord 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Sinos Were autopsy findings available prior to completion of cause of death? 24a. Was an as e 2 autopsy certificate ha Yes 2 No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this ( Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? (Month, Day, Year) Natural 5 Pending injury Accident Investigation l Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) n 24 hou. the Funeral Dire Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) N. Chorles St. Balts Md 21204 Bine

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David t	Bardalman

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State of Maryland / Department of Health and Mental Hygiene

avid L Bardeima		State of Maryland / Departmen 1- For State Certificate Registrar	nt of Health and Mental e of Death	rygiene	2010	525
Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month	)ay Year	Time of Death
Medical Examin		David L. Bardelman  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	May 13, 201	4c. County of Death	1802 hrs
		Prince George's Hospital Center	Cheverly	, au t	Prince George's	i
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda			(MM/DD/YYYY) 9. Birthp	blace (State or Baltimore,
Director		217-58-8695 13M 2 F 46	Yrs. Months Days Hours I	March	30,1964 Coun	maryland
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	Location		1	0d. Inside City Limits
<b>≜</b> .	١	Maryland Prince Georges Co. Blade	nsburg			Yes 2 X No
/aryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Countr	y?
h the l		3304 Kenilworth Ave.	20710		Jnited State	
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28s-f sho ent, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue</li> </ol>		14. Race - America White, etc.	n Indian, Black,
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes Give Year	1 Yes 2 No specify:		Specify: Wh:	ite
nours a	od be	dur	cedent's Usual Occupation (Give kinding most of working life, DO NOT use		6b. Kind of Business/Ind	lustry
36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A	Laborer	ŕ	Salvation	Armv
d with ygiene other t	탉	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma		2
215 be file antal H rked of	å	George L. Bardelman		. Hook		
MD 21215-0036 at 2 should be filed within 7 and Memtal Hygiene. In 27 is marked other than a market other war aumatic event, the Medica	욘	//1	Mailing Address (Street and Number			
and 2 lealth traum	ŀ	20a. Method of Disposition 20b. Place of D	4633 Willowgrove Disposition (Name of cemetery,	Drive F	Ellicott Cit 20c. Location - City or To	own, State
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		1 Burial 2 Cremation 3 Removal from State Evan's Fu	eral Chapel and Ma	ıy 16,2010	Harford) Forest Hill,	(cb.) Marvland
Baltimore, permit. Pages l an Department of He. Important: If ite	t	21. Signature of Funeral Service Licensee Jeffrey L. Gir.Sr.	on Services  22 Name and Address of Facility Peace 111 Alternative			
	-1	23d Part I/Enter the disease, or complications that caused the death. Do not e	2325 YOUK ROBO	Timonium, M	aryland 21	093 Approximate Interval
Physician Medical	4	failure. List only one cause on each line.	Ther the mode of dying, such as cardia	ic or respiratory arres	, SHOCK, OF HEAR	Between Onset and Death
Examiner	-	Immediate Cause (Final disease or condition resulting in death)  a Liver cirrhosis  Due to (or as a consequence of):				
	_	Sequentially list conditions, if any, leading to immediate  b				
	Examiner	cause. Enter Underlying Cause				
ted I Insit	Exa	events resulting in death) Last Due to (or as a consequence of):				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Ea -	IF FEMALE:  AMENDED  23a, PII,27, per  23c. If yes, outcome of pregnancy	ME ~90/ 6/18/10 7	יייי		
760, cate be physic the bur	₩.				23d. Date of delivery	
ox 6876 eath certificate attending phy for use as the	Sian	past 12 months?  A Pregnant at time of death 5	Fetal death 3 Ectopic pre Other (Specify)	gnancy	Month Day	y Year
BOy e death the att	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		Las addition		
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of Vital Records, ag Physician: The law requirements of the this certificate has been someral director, page 2 should be		25. Was case referred to medical	26.Place of Death (Che		10 10	2
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n of ding P h. After funera		27. Manner of Death  1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)  28b. Tim	e of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
	<u>icati</u>	2 Accident Investigation 28e. Place of Injury - At home, farm		28f. Location (Str	eet and Number or Rura	Route Number, City
Division of Vospital or Attending Ph.  Hours after death.  Inneral Director: After to the filled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	te)	
8 4 5 7		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inve				
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or inversely and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	
	_	Il Mid To	O.C.M.E.	DOME	May 14, 2010	
$\propto$	}	30. Name and address of person who completed cause of death (Item 23a)	<i>a</i>			
40 /		Theodore M. King, Jr., MD. Assistant Medical Examine	er 111 Penn Street, Baltim	ore, MD 21201		
Sta Registi	_	31. Date filed (Month, Day Year) 32. Fegistrar's Signature	barrel			
DHMH 17 Rev 1/20	01	ORIG	INAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MAY 1210 M 2010 Joe D. Colvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Kansas 80 Director 512-26-2702 Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits show 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 K XNo MD Lansdowne Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 2114 Alletta Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 √Yes 2 No If Yes, Give Year or Dates: 1946-1 Never Married 2KM Arried Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: à White 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) 10 Food Distributor Owner-operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Colvin Mary Lee Crutchfield traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau once. Betty I. Colvin - wife 2114 Alletta Avenue, Lansdowne, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 05-11-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign our of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
DAYS Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has MELLITUS DIABETES 1 ☐Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 💉 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ie Hospital or A 24 hours after ie Funeral Direc 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29b. Signature apolitile of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0054257 alme, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AV. BALTIMORE 21229 MANJUL SHARMA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Anne Clark	State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg. No. 2 1 1 5 2 5 8
Physician/	Registrar
/Pilysiciali Medical Examiner	Month Day Year 1025 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	1207 Addison Road # 414 Capitol Heights Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	416.58.5669 1 M 2 XF 69 Yrs. WILLIAM OCT 11 1940 A TOBAMA
è	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
10 W BI	MAN D C No
Maryland 28a-f show any d at once. ector	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
or 28 Oire	1207 Addison Road #414 20743 USA
r death with the Maryland or items 23a or 28a-f sh must be notified at one Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
death r iten nust t	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
s after ral", o	3 Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 1 Yes 2 ☑ No specify: Specify: Specify: Specify:
hours Fram Fed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
36 han " han "	Elementary/Secondary (0-12) College (1-4 or 5+)  Child Davelmment Education
215-0036 be filed within 72 hour ntal Hygiene. rked other than "natuent, the Medical Exau Be Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname),
215 be file ntal H rked o ent, tt	Lafavette Cooks Bennie Z. Herron
D 21 Sould   d Mer is mar tic ev	19a. Informant's Mene/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Tonya D. George Claughter 5914 Cherrywood Terrace #304 Greenbett Dzom
ore, slar of Hez If ite	20a. Method of Disposition 20b. Place of Disposition (Name of cometery, 1 Surial 2 Cremation 3 Removal from State crematory or other place) 20c. Location - City or Town, State
	4 Donation 5 Other Specify: King Park 5. 22.10 Baltimore MD
Baltimore, permit. Pages La Department of He Important: If ite	21. Signature of Funeral Service Licensee / 22. Name and Address of Facility Vaughn Coreene Funeral Services
Physician	Uaughu C. Linear 5151 Baltmore National Pike (21229)  23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate interval
Medidal	failure. List only one cause on each line.  Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):
	Sequentially list conditions, b
ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause C.
red Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
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0, the execution is be executed in the control of the edical	UNPENDED #1perME.G905.7/26/2010.WS
). Box 68760, the death certificate be ever the attending physician cled for use as the burial cled fo	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery 23d. Date of delivery
x 61 th cert tendir ruse a	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
Bo he deat the at	1 Yes 2 No 9 Unknown 9 Unknown
Division of Vital Records, P.O. Box 68760 retal or attending Physician: The law requires that the death certificate than sife death.  The Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the buerification: To Be Completed by Physician/Me	
Records, P.( The law requires tha ficate has been signed a page 2 should be det. Completed by	24a. Was an 124b. Were autopsy findings available
cords aw requi	autopsy prior to completion of cause of performed? death?
tal Recortian: The law certificate has ector, page 2 si	1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician: ician: s certi rector	25. Was case referred to medical 26. Place of Death (Check only one)
of Vi ing Physi After this funeral dir on: To	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
On C inding ith. Af	1 Ves 2 No
/isic r Atte ter dez irecto irecto ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town State)
Division of Vital Records, spital or Attending Physician: The law requirours after death.  neral Director: After this certificate has been stilled in by the funeral director, page 2 should Certification: To Be Completed	4 Homicide Ospecify or Town, State)
t Hosp 24 ho Fund Fund etely f	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn Medical Certification: To Be Completed by Physician/Med	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  May 12, 2010
	and the state of t
	30. Name and address of person who completed causle of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State	31 Date filed (Month, Day Year) 32 Registrar's Signature
Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 14 Physician/ Wanda Josephine Dietz 5:45 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Jarrettsville Madonna - Heritage, Inc. If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 25CXF Hours 011/24/149 New Jersey 91 **Director** 180-03-1279 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Rosedale Maryland 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21237 U.S.A. Funeral 8419 Avery Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces 1 Never Married 2 Married Yes 2 X No by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Operator Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Clara Davidowski မ Antoni Rash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Rash, Sr. (Brother) 11 Covington Drive, Shrewsbury, Pennsylvania 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 105/20/2010 Gardens of Faith Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. Signature of Funeral Service Licent 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Ster the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate shock Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death 0-Physician/ Medical Due to (or as a c ... equence of): Examiner mei Sequentially list conditions Examiner cause. Enter Underlying
Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit mentio that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1110 Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 24 hours after deatle Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check The retifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 To the I 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. State Registrar

DHMH 17 Rev 7/2009

0-03666 Daniel Michael I	Devr		pe or Print ate of Mary								.egib	le. 2 11		526
		1- For State Registrar			Certifi	cate of L	Death				Reg. N	1.00	1 0	020
Physici		1. Decedent's Name (First, Midd	lle,Last)						2	Date of D	eath			3. Time of Death
Medical Exami	ner	Daniel Michael DeVries  Month Day Year May 12, 2010										1512 hrs		
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Upper Chesapeake Medical Center  4c. County of Death  Harford												
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last b	irthday)	If Under 1 Yea			8. Date of	Birth(MI	M/DD/YYYY		hplace (State or
Director		212-23-5382	1XM 2 F		21	Yrs.	Months Day	/s Hours	Min.	Nov.	15,	1988	Foreig Co	aryland
th the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Har  10e. Street and Number	ford	10c.	•	on or Location					10g. C	itizen of Wh		10d. Inside City Limits
the M n or 2 tiffed	D I	2709 Lawson R	Oad				21047				Uni	ted St	ate	s
r death wi or items	y Funeral		Armed  1 Yes  Vorced If Yes, Give Yes	ecedent Ever Forces? 2XX		If Yes	Decedent of Hi	n, Mexican	, Puerto Ri				- Americ	can Indian, Black,
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe-	or Dates: cify only highest gr	ade complete	ed) 16a		Usual Occupa				16b	. Kind of Bus	siness/li	ndustry
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21215-0036 mid be filed within 7 Mental Hygiene. marked other than c event, the Medica	Ę	12			В	ody &	Fender	Repa	irman			Automo	otiv	e
215-0 be filed v ntal Hygi rked oth ent, the l		17. Father's Name (First, Middle,	•					18.Mother	's Name (F	irst, Middle	e, Maide	n Surname)		
21215-0 ould be filed w I Mental Hygic s marked othe ic event, the A	Be	David M. DeVr							ea Sc					
O 8 5 2 2 1	٩	19a. Informant's Name/Relations David M. DeVrie		Fathe	- 1		ddress (Stree Jawson I					City or Town		Zip Code)
ore, ME		20a. Method of Disposition  1 Burial 2 Cremation	2 D D	from State 7	20b. Place	of Disposition	on (Name of ce	metery,	May	ate 1 ⊑	200	. Location -	City or	Town, State
Page Page		4 Donation 5 Other St		nom State		el Air		beτ	20	-	E	orest	<b>u</b> +1	l, Marylan
Baltir permit. 1 Departm Importa injury o	- 1	21. Signal ve of Funeral Service				22. Nan	ne and Address	s of Facility	hanal	0 C=		oresc	1111	ice-Belair
<b>0</b> 2011		for set	say (			3 Ne	wport I	Drive	For	est F	lill	, Mary	erv lan	d 21050
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.		leath. Do i	not enter the	mode of dying,	such as c	ardiac or re	espiratory a	arrest, sl	hock, or hea	rt	Approximate Interval Between Onset and Death
LAdillilei		or condition resulting in death)	Due to (or as	a consequer	nce of):									
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b Due to (or as	a consequer	nce of):									
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a a	Si	UNPENDED	AMENDED						·					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in th past 12 months?  1 Yes 2 No 9 Unk	ne 1 Live	nant at time		2 Fetal	death 3 - (Specify)	Ectopio	pregnanc	/	2	3d. Date of o	delivery D	ay Year
, P.O. E res that the d signed by the be detached	<u>ā</u>	Part II. Other significant conditi	ions contributing	to death but	not resulti	ing in the und	erlying cause of	given in Pa	rt I.	1	tobacc		Proba	he cause of death?
Division of Vital Records, F tal or Attending Physician: The law requires rs after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed									24a. Wa	as an opsy formed?	24b. W	ere aut	opsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical	_						(Check only	one)				
Vit hysici	0	examiner?  1  Yes 2 No	Hospital: 1	Inpatient 2	2 🗸 ER/0	Outpatient 3	DOA	Other <sub>4</sub>	Nursing H	lome 5	Resid	lence 6	Other:	
ion of V tending Phy eath. tor: After tl	tion: T	27. Manner of Death  1 Natural 5 Pend	ding May 12	of Injury h, Day Year) , 2010		. Time of Inju 24 hrs		ry at Work Yes 2 ✔	lO <sub>r</sub>			ijury occurre orcycle in		d in collision
Divisi pital or Att ours after de teral Direct	Certification:	3 Suicide 6 Coule	d not be	ce of Injury -		farm, street, t	factory, office b	ouilding, et		or Town	. State)	and Number		al Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	20a Cortifier	hysician: To the be miner: On the basis and manner	of examinati										
- × ± 3	Me	29b Signature and title of certifie		- Pa	lla	K	29c, Licens O.C.I					Date signed	·	th, Day, Year)
71	ĺ	30. Name and address of person Patricia Aronica-Pollal		use of death ( tant Medic	,		11 Penn St	reet, Ba	Itimore,	MD 212	01			

State 31. Date filed (Month, Day, Year)
Registrar AY 17 2010

32. Registrar's Signature A. parl

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ MAT 2010 DENNIS 02:30A M IRVING Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE 7121 PARK HEIGHTS AVENUE, 6. Sex 1 💢 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 0771071924 088-12-9586 NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21215 7121 PARK HEIGHTS AVENUE, #502 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Ves 2 No Specify: 3 Divorced 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER ADVERTISING Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည DENNIS IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7121 PARK HEIGHTS AVENUE, #502, BALTIMORE, MD 21215 ROSALIND DENNIS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/14/2010 REISTERSTOWN, MD OHEB SHALOM CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign (ure) f Funeral Service L. ense 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER PROSTATE Physician/ METASTATIC 19 YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to jor as a consequence of Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Tyes Accident Investigation after death the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by Homicide determined City or Town, State) 24 hours 29a. Certifier 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 12 2010 D28768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 ORLEANS STRET IN-SI BALTIMORE, MD 21231-1000 A. EXECUDENCEN MANIO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

32. Regi krar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Year **Physician** DISNEY FRANK 3:01 PM May 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore washington medical Center Burne If Under 24 Hrs. 8. Anne Aronde Glan If Under 8. Date of Birth (Month, Day, Feb. 20 Birthplace (State or Foreign Country)
 Mary Land **Funeral** Days Months Director 215-28-6296 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a State 1 □Yes 2 XNo Director Anne Arundel Baltimore Maryland Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21226 U.S.A. 1003 Fieldstone Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland Drydock Co. Mechanic 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henderson Catherine Norman Disney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1003 Fieldstone Place, Baltimore, Maryland 21226 Nancy A. Disney (Wife) Department of Health Important: If item 27 any Injury or other troone. 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park May15, 2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funer Prvice Licen 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imperiate Cause (Final disa se or condition sulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Inknown 1 Tyes 24a. Was an

Physician

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

Division of Vital

Fronk

Disney,

cate has been signed by the page 2 should be detached certificate funeral director, this After t

Certification: To

autopsy performed 1 ☐Yes 2 ☐No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatient	3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	ury occurred

1 Natural 5 Pending investigation 2 Accident 3 Suicide

29b. Signature and title of contifier

4 - Homicide

6 ☐ Could not be

М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Conn

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address who completed cause of death (Item 23a) (Type, Print) WASMILONA BARIMONE

405pinh egistrar's Signature

State Registrar

Medical

nours after death.

neral Director: A
y filled in by the fu

within 24 hours a

To the Funeral D

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death E well Physician/ May Jennie Medical 4a. Facility Name (if not institution, give street and number) Examiner 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or item. 10a. State Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 ☐ No more 10f. Zin Code 10g. Citizen of What Country? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Qa. Informant's Name/Relationship (Type, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 1229 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End Stage Alzheimers bementia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes been signatures Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed r this certificate h ral director, page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other Specify ျာ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? After 1 Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D0057465 9-13-10 1) SKaj apahol M.D.

State Registrar 2835 Smith AV.

5-235 - Baltimon, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Dona S. Fisher 2010 : 50A May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Center Baltimore County Towson 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Min **Director** 206-18-8608 84 Yrs. Pittsburgh, PA 1926 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Baltimore County Lutherville 1 Tes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 151 Westbury Road 21093 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 12 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William H. Schutte Rosanna Zern 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
(Daughter/Only Ch: 151 Westbury Road Lutherville, MD. 21093 Christine F. Tennies 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel and 1 ☐ Burial 2X Cremation 3 ☐ Removal from State (Harford Co.) injury or May 14,2010 4 Donation 5 Other (Specify) Forest Hill Maryland Services 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center 2325 York Road Timonium, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SEPSL Immediate Cause (Final et and Death Physician/ disease or condition aus Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit pheral that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate | 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2X No Hospital: Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Deatl 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

NEUSSA 31. Date filed (Month, Day, Year) State Registrar

only one)

and title of certifier

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30. Name and address of person who c

29b. Signa

propleted cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

3XX Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

HARUES ST.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 26/ 0 208 M Rebecca Fischer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death • 31436444 HICIMICO TENINSULD ROGIONAL MHU If Under 1 Year If Under 8. Date of Birth 0 (Month) Day, 1938 **Funeral** 7. Age (In vrs. last birthday) Hrs 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Maryland 218-32-6858 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Somerset Eden 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral USA 21822 14232 Carver Manor Cir 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ Maryland 21215-0036 white 1 Yes 2 No Specify: "natural" 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) poultry age 1 and 2 should be filed with of Health and Mental Hygien t: If item 27 is marked other tl or other traumatic event, the farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cathryn Virginia Nelson Hammond Revell Betts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26441 Cottman Road; Eden, Maryland 21822 Cheryl Moore/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 Donation 5 Other (Specify) 21. Signature nal State Anatomy Board; 655 W. Baltimore Street altimore, Maryland 21201 23a. Part 1. En er the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or con hij n resulting in death Onset and Death Physician/ NEUMONI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burlal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 D Fetal death 23b. Was decedent pregnam 23d. Date of delivery 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death 1 Yes 2 Ug Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After his certificate has funeral director, page 2 autopsy performed? ☐ Yes 2☐ No 1 Tes 2 Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending ☐ Accident 1 Yes 2 No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the only one Certifying Nurse Practioner: To the best of my knowledge, dealth soon d at the time, date and plane, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL St. SALS bury Md. 21801 MAHESHA V. ThimMARAYA MD ODA 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month ma Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hve reensprino Himore Dwings 115 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Director 65 217-40-8895 Sept.09.1944 Dunkirk, N. Y Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County 1 Yes 2 X No Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12330 Greenspring Ave. 21117 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales 12 Merchandise Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Charles Grewe Virginia Harding 19a. Informant's Name/Relationship (Type, Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Carmenza Luz(nee Valdeblanquez) Grewe 12330 Greenspring Ave. Owings Mills, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and 20c. Location - City or Town, State 1 Bunal 2X Cremation 3 Removal from State May 14, 2010 (Harford Cb.) any injury or 4 Donation 5 Other (Specify) Forest Hill, Maryland n Services
22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093-2215
Approxima Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 23a. Raft 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hepatocellules cances Immediate Cause (Final Physician/ advanced 200 disease or condition / Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops perfor 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 2 No 1 Yes Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature D53070 5/14/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orleans 54 31. Date filed (Month, Day, Year) 32. Registra's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10f, per Fh 2903 5/17/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NANCE **GAMSE** 07:53P M 20/0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8 Date of Birth 1 🗆 M 2 🕱 F Days Hours Min Months 0970571918 Director 214-82-9522 91 V٨ Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No MD BALTIMORE PIKESVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT WILSON LANE USA <del>21117</del> 21208 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedon. Armed Forces? ¹ ☐ Yes 2 🗶 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 XWidowed 4 □ Divorced If Yes, Give Year or Dates "natural", Completed Specify WHITE event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. **HOMEMAKER** OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CLARENCE SOL BLOOMBERG MIRIAM ROSE HIRSCH permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN GAMSE / SON 100 HARBORVIEW DRIVE, PH-1C, BALTIMORE, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) SHALOM MEM. PARK 05/14/2010 REISTERSTOWN. MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to in rediate cause. Enter Underlying 4100 Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last ) G. and the burial-tran Due to (or as a consequence of) signed by the attending physician. Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. Mo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy perform death? 2 🗆 No Yes 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death Check only one examiner? Certificate: To 1 Tyes Other 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 V Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title Name and address of person who completed cause of death (Item 23a) (Type, Print) old 00 pan M 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A Year 1723 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death TON 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NOCTO PAROLINA **Funeral** 8. Date of Birth Hours 1 🗆 M 2 🗶 F Months Days Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 XNo Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ABORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of CE cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) frun ral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes 2 € 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗌 No Yes 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA rsing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accide 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Sulcide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. certifie who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 9.35 Mar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore potal Baltimore 5. Social Security Number 319-30-66 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign last birthday 8. Date of Birth **Funeral** 6680 1 🗆 M 2 🗷 F Hours Min (Month, Day, Director Yrs Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a, State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Baltimore 1 Yes 2 No Annie Harris 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral USA 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian ☐ Yes 2 No If Yes, Give Year or Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' onday (0-12) College (1-4 or 5+) nestic Be 17. Father's Name (First, Middle, Last) 18-Mother's Name (First, Middle Maiden Surname) 19a| [nformant's Name/Relationship (Type, Print) Mailing Address Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other place) 20a. Method of Disposition 20c. Location 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature A Tuyeral Service Li & nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician valcular disease or condition days Medical resulting in death) Due to (or as a consequence of): <sup>1</sup>Examiner mila Sequentially list conditions, any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of sician and burial-transit Cause (Disease or linjury that initiated events Congres Due to or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Munknown Completed ten 500 1 🗌 Yes page 2 should . Were autopsy findings available prior to completion of cause of death? disease ( aronam 24a. Was an has autopsv Yes 2 After this certificate 1 Yes 2 M No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 M No မ 1 Tes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu death. 1  $\square$  Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D 12 2010 Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNIREDO Baltimore MA TUAZ Sinas MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 10c d per fh g903 5-17-10 yt
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13, 20, Year **Physician** onstance /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE ITOSPITAL GNES 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗹 F 214-22-87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 1 timore Gwynn Oak 10g. Citizen of What Country? 10e. Street and Number 9 Bonnie Jean Ct. 21201 by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 1000 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life:~DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be endell ninor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) laude occistock 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5-19-2010 13a Himore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vauchn C. Greene Funeral Services 21. Signature of Funeral Service Licenset 8728 Liberty Road, Randalls town mo 21133 23a. Part 1. Enter/De disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Unknown Immediate Cause (Final disease or condition resulting in death) **Physician** 41 house levotre /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examine burial-tran Due to (or as a consequence of): the attending physician ned for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 ☐ Unknown Completed certificate has been ector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 10 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0068107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Avenue 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day 12 Year Physician /Medical Hamer 2010 16:25 May obert 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number vrs. last birthday **Funeral** 1 M 2 □ F Months Days Hours Director Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show notified at 1 res 2 No Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 5 must be 23a Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after and the filed within 72 hours after a nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 þ "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7 is marked other than traumatic event, the Me Mother's Name (First, Middle, Maio 17. Father's Name (First, Middle, Last Be ည Department of Health a Important: If item 27 is any injury or other tra once. OHER 20a. Method of Disposition 2 Cremation 3 Removal from State Burial Donation 5 Other (Specify) 21. Signature of Funeral Se vice Dicenses MOIS OKK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ching, such as cashock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Hodykins **Physician** 14my norm disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Vear in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 🗌 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Tyes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DDA Medical Certification: To 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death.

To the Funeral Director: After completely filled in by the fune 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) KEG-1000 2010 son who completed cause of death (Item 23a) (Type, Print) Minder Michael 600 North Wolfe St, Baltimore, MD, 21287 Camille egistrar's Signature 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical **Examiner** Eacility Name (if not institution, give street and number) City, Town, or Location of Death Himore easons Hos ls towr 8. Date of Birth . Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 9. Birthplace Country) 1 🗆 M 2 💢 F **Director** Yrs 28a-f shov 10b. County filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Pres 2 No more 10e. Street and Number 10g. Citizen of What Country? Funeral 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 o If Yes, Give Year or Dates. Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation ecify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) conday (0-12) College (1-4 or 5+) and Mental Hygie is marked other Be Father's Name (First, Middle), Last, 's Name (First. ddle. Maiden Surname permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ TON 19b. Mailing Adda eet and Number or Rura Route Number, City or Town, State, Zip Code, Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 Cremation 3  $\square$  Removal from State timore. 4 Donation 5 Other (Specify) 21. Signetur of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has ; page 2 autopsy performed? Yes 2 death? certificate I director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes ည After this 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Accident
Suicide To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) State 32. Registr Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 11, 2010 Year Physician/ 2:20p Mary R. Harris Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Joseph Richey Hospice, Inc 8. Date of Birth (Month, Day, Year) Oct 21, 1928 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday Funeral Days Hours 1 □ M 2 😿 F No. Carolina Director 217-30-5057 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Raltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21223 2586 Edmondson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MNo Specify. Black Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "' Westinghouse Elementary/Seconday (0-12) College (1-4 or 5+) Key Hole Puncher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Anna Faulcon Charlie Faulcon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 590 Lucia Avenue Baltimore, Maryland 21229 Ernestine Wilkinson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DeBurial 2 Cremation 3 Removal from State Owings Mills, Md. 05/17/10 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Juneral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 Migen 23a. Pa. 1. Enty the disease, or complications that caused the shock, the eart failure. List only one cause on each lin eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Henatocellwar Physician/ Medical Due to (or as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Hypertension Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 🗌 Unknown g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Unknown 1 Tes 2 No 3 Probably Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s performed 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation after death 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0067817 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mary	•			lental Hy	giene	2010	15271
			State Registrar	-4\	Ce	ertificate of l	Death	0.04.60	Reg. N	<u>.4UIU</u>	13214
	Physicia	n/	1. Decedent's Name (First, Middle, Las Robert Bret					2. Date of De Month May		ay 2010 ear	3. Time of Death 9:15 A M
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of Death	ilay		c. County of Deat	
	LAGIIIII	GI.	7815 Turning C			1 " _ '	comac			lontgome	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	g. Bir	thplace (State or Foreign
	Director		172-01-5009 Usual Residence of Decedent	89	Yrs.			(Month, Da February	8, 1	921   Pen	nsylvania
	and show lat	P	10a. State 10b. County	10	ic. City, Town or l	ocation					10d. Inside City Limits
	Maryl 28a-f otifiec	irect	Maryland Montgo	mery			Potomac				1 Tyes 2X No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code	2005/			citizen of What Co	
	ath wil	ner	7815 Turning Cre	ek Court	in II S 13		20854	ecify Yes or No-		14. Race - Ame	
(O	er deg or ite	by F	1 Never Married 2 Married	Armed Forces?	110.0.	. Was Decedent of H If Yes, specify Cuba		Rican, etc.)		Black, White	
Ŏ3	ırs aft ural", IExal	ted t	3 Divorced	If Yes, Give Year or Dates. WW	III _	1 ☐ Yes 2 🕅 No	Specify:			Specify: Wh	ite
5-(	72 hou "nat edica	Completed	15. Decedent's E (Specify only highest gr		(Giv	edent's Usual Occup e kind of work done	during most of work	ing	16b. l	Kind of Business	Industry
2	ithin 7 ene. r than the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5+) 4	i	DO NOT use retired) O <b>ker</b>	,		Ins	surance	
d 2	iled w I Hygi othel rent, i	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,			
/lar	d be f Menta Menta arked atic ev	욘	Benjamin Hart				Grace I	Lehmer			· · · · · · · · · · · · · · · · · · ·
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Health and Mental Hygiene.  The marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	ype, Print)		ling Address (Street					
<u>ک</u> نه	and 2 Health em 27 ther t		Janet F. Hart / N	Wife		Turning oosition (Name of	-		T	ac, Mary	land 20854
יסר	tge 1 and of		1 🗌 Burial 2 🗓 Cremation 3 🗆	Removal from State	cemetery, cr	ematory or other pla	ce)	Date		•	
語	permit. Page 1 a Department of I Important: If ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (Special Service Licentary of Funeral Service Licentary Serv			Crematorium					y Chase, Inc.
Ba	Dep Imp any ono		> John John	~		557 Wiscons					
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the							Approximate Interval Between
, 1	กysician/	e Y	Immediate Cause (Final disease or condition		ung Can	cer					10 Months
	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):						
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of:						
ini-	ited d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury	`							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director.	I Ex	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
09	ate be hysici the bu	dical		d				_			
Division of Vital Records, P.O. Box 687	requires that the death certifica been signed by the attending pl should be detached for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy					23d. Date of de	divor
ŏ	atten atten I for u	iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су			Month Month	Day Year
Э.	the de by the ached	hys	g 🗌 Unknown	g 🗌 Unknown							
P.O.	s that gned be	by P	Part II. Other significant conditions of	contributing to death but n	not resulting in the	underlying cause gi	iven in Part I.				o the cause of death?
ds,	quires sen sig ould b	ted				_					Probably 4 Unknown
Ö	law re nas be e 2 sh	Completed						24a. Was	nsv	prior to	topsy findings available completion of cause of
Re	sician: The law r certificate has b irector, page 2 s		25. Was case referred to medical					perfe 1 \sum Yes	2 🔼 1	No 1 TYe	s 2 No
/ital	lysician: is certific director,	o Be	examiner?  1 \sum Yes 2 \sum No	Hospital:	2 🗀 ER/Outpat	Oth	Place of Death (Check		danaa	6 ☐ Other (Spec	o.(6.4)
of \	ding Phys :h. After this funeral di	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Ye	28b. Time	of 28c. Injur	ry at	28d. Describe			
O	eath. or: Aft	ficat	1 XNatural 5 Pending 2 Accident Investigatio	n	sar/ Injury		Yes 2 No				
Visi	or Atter fter de irecto n by tl	Certificate:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined			treet, factory, office		28f. Location ( City or To			ıral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		29a. Certifier 1 💢 Certifying Phy	rsician: To the best of my	knowledge deet	a accured at the time	a date and place or	ad due to the co	auco(e) s	and manner as st	ated
	e Hos	Medical	(Check 2 Medical Exam	niner: On the basis of examples Practioner: To the bes	nination and/or inv	estigation, in my opini	ion, death occurred a	t the time, date	and plac	e, and due to the	cause(s) and manner stated.
	To the within to the comp	2	29b. Signature and title of certifier		, ,	29c. Licens				ate signed (Mont	
			100			D430	83		May	11, 201	10
1.1			30. Name and address of person who	completed cause of death	n (Item 23a) (Type	, Print)	#200	D c c1	11.	Mazzr1 a	and 20850
151			George A. Sotos,	M.D. 970/ 1	Medical Signature	center Dr	rve #300,	KOCKV1	тте	, maryia	1110 20000
4	Sta Registra		MAY 17	32. Redistrar's	~ A.	parke					
DHV	ИН 17 Rev 7/20	009									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 4 Day 2010 Physician/ OCAP M HICKS THEODORE BELL SR Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Deat Examiner BACTIMORE WACHINGTON MEDICAL ANNE UNITE oten If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral County) and 1 🗶 M 2 🗆 F Months Days Hours SiMonth Day, Year 219-18-7653 84 ,1925 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Pasadena 1 Yes 2 No Maryland Anne Arunde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1452 Theis Drive 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Furniture Co. I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Maker marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked our yory or other traumatic events. 0 Robert Hicks Doris Be11 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 22. 19a. Informant's Name/Relationship (Type, Print) (Step-1452 Theis Drive, Pasadena, Maryland Patricia A. SeBour Daughte Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Glen Burnie Md. Atlantic Crematory 5-16-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Lio 22. Name and Address of FacilityMcCully-Polyniak F.H. P.A. 3204 Mountain Road, Pasadena, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. mmediate Cause (Final Onset and Death Physician/ METACTATIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Due to for as a consequence of The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by the a the 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A A Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? **Division of Vital** Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient မှ 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After iniury work? Natural 5 Pending 2 🗌 No 2 Accident Investigation after death Director: / the 6 Could not be within 24 hours after dear To the Funeral Director completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat 29d. Date signed (Month, Day, Year) 164 2010 ne and address of person who co leted dause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yea State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month May 3. 2010 Maryland Ε. Jestes 1:20 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel 1307 Damascus Street Odenton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 04-21-1939) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex Year 1 M 2 F Months Mary Tand 71 219-34-9874 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 XINo Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21113 1307 Damascus Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

1 ☐ Yes 2 🗓 No

Homemaker

20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crematory

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify

**Physician** /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic event.

**Physician** 

/Medical

10a. State

MD

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

College (1-4or 5+)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

Norman Tucker

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

21. Signatur of Funeral Service

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print) Joseph E. Jestes - spouse

4 ☐ Donation 5 ☐ Other (Specify)

Director

Funeral

à

Completed

Be

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Examiner

Physician/Medical

þ

Completed

Be

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Certification:

Medical

(Check only one)

Examiner

**Funeral** 

Director

Examiner

The law requires that the death certificate be executed attending physician a for use as the burialthe s been signed by the should be detachε cate has b page 2 s certificate I To the Hospital or Attending Physician: this After thi funeral of

Box 68760,

P.0.

Division of Vital Records,

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Hinknown 9 Unknown 24a. Was an autopsy performed? 1 □Yes 2 100 25. Was case referred to medical examiner? Hospital: Othe 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. In W 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide certifying Physician: To the best of my knowledge, 29a. Certifier 2 Medical Examiner: On the basis of examination an

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cancer

as a consequence of):

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Month

Specify:

Own Home

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1307 Damascus Street, Odenton, Maryland 21113

05-08-2010

Mamie Virginia Ross

22. Name and Address of Facility Gary L. Kaufman Funeral Home at

MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075

16b. Kind of Business/Industry

20c. Location - City or Town, State

Glen Burnie, MD

Approximate Interval Between Onset and Death

Year

White

24b. Were autopsy findings available prior to completion of cause of death? 2 2 No 1 ☐ Yes

Day

26. Place of Dea	ith (C	neck only one)	
r: 4 🗆 Nursing H	lome	5 Residence	6 ☐ Other (Specify)
		Describe how inju	

4 L Nursing H	ome	5 Residence	6 ∐Other (Spe
jury at ork? □Yes 2□No	28d.	Describe how inju	ury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

d/or investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)
COo Lineare number	20d Data signed (Manth Day Year)

29b. Signature a	and title of certifier		29c. License number
	Solp	MD	D3895

and manner stated.

Crain Highway Sw Glen Burnie MO2109

-	-										
മ	Name	and	address of	nerson	who	completed	cause (	of death	(Item 23a)	(Type.	Print
7	- Traine	71	address of	7	6	1 0	11		, ,	•	-

WYD Datiel SINYLDIUM

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year Marjorie A. Jennings JAL 2.50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Augsburg Lutheran Home Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/11/1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2**X** F Months Days Hours Min. 89 Director 218-05-6641 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits rd other than "natural", or items 23a or 28a-f sho event, the Modical Examiner must be notified at Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2010 Windys Run Road 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. À Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed withii Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Candy Packer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Therres Anna Schreiner traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau Linda A. Woods (Daughter) 2010 Windys Run Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation Loudon Park Cemetery 05/17/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one hause on each line. Onset and Death Immediate Cause (Final **Physician** THERUSCLERUTIC EREBRO VASCULAK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 10 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy The certificate 1 ☐ Yes 12 ☐ No Division of Vital 1 ☐ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1□Yes g No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural Jepital c.
4 hours after des.
--eral Director: After 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) And 24 hours The Funeral Direst filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2. the

State Registrar 29b. Signature) and title of certifier

31. Date filed (Month, Day,

Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) AKHAM

DHMH 17 Rev 1/2001

mi

29c. License number

28195

203

29d. Date signed (Month, Day, Year)

10-03627 Bruce Jato Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ruce Jato		State of Maryland / Department of Health and 1- For State Certificate of Death	Mental Hy		201	1 5278
Physicia		Registrar  1. Decedent's Name (First, Middle, Last)	2	Reg		3. Time of Death
ledical Exami		Bruce Jato		Month May 11, 20		0800 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo 441 Nicoll Avenue  Baltimore	cation of Death		4c. County of De	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	For	Birthplace (State or reign
Director		214-39-1393 12M 2 F 32 Yrs.	110010	05/18/	1977	Country) Cameroon
any	ł	Usual Residence of Decedent  10a. State				10d. Inside City Limits
Maryland 28a-f show any <u>1 at once.</u>	ō	MD Raltimore				1 Yes 2 No
e re	Director	106. Street and Number  441 Nicoll Avenue  21212	7,	100	g. Citizen of What C USA	ountry?
with thems 23a be notii		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa	nic Origin? (Spe		14. Race - An White, etc	nerican Indian, Black,
er deatl	Funeral	Armed Forces?    Armed Forces?   If Yes, specify Cuban, No.		,	Specify:	Black
ours aft atural"	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during most of working life. Di	(Give kind of wo		6b. Kind of Busine	
5-0036 led within 72 hours afte tygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		u)	Camp	USA
d with ygiene other the Mer	Com	17_Eather's Name (First, Middle, Last) 18.	Mother's Name (F		aiden Surname)	01071
21215-0036 uld be filed within? Mental Hygiene. marked other that c event, the Medics	o Be	Johnson Jato  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street a	Miriam	Ngw		ato Zin Code)
Baltimore, MD 21215-00: permit. Pages I and 2 should be filed with Department of Health and Mental Hygeine Important: If item 27 is marked other Injury or other traumatic event, the Met	۲	1		Baltin		uland 2/2/2
re, N s 1 and f Health If item		20a. Method of Disposition  20b. Place of Disposition (Name of cemel	tery,	Date	20c. Location - City	or Town, State
altimore, mit. Pages I a spartment of He aportant: If ite jury or other ti		4 Donation 5 Other Specify:   Yoreland Memoria		1   2010	KJa HIMOre	Maryland
Balt permit. Depart Import		Zi. Official of the district	reene F.S	. Hal	fimore, Mo	cryland 21212
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the plode of dying, suffailure. List only one cause on each line.	ch as cardiac or r	espiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a MRSA Sepsis  Due to (or as a consequence of):				Death
	Ļ	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
uted nd ransit		events resulting in death) Last events resulting in death) Last d.				
0, be executed sician and burial - transit	edical	$\square$ AMENDED 23a,27,per ME g904 6/18/10 TT	ŗ			
6876C certificate anding phys	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnanc	Су	23d. Date of delive Month	very Day Year
Box 6876( he death certificate r the attending phy hed for use as the b	Physiclan/M	past 12 months?  4 Pregnant at time of death 5 Other (Specify) 9 Unknown				
2 2 E3		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
S, P.O. tires that the signed by d be detack	ed by					robably 4  Unknown
cords, law requir has been s	Completed			24a. Was an autopsy perform	prior	to completion of cause of
tal Rec		25. Was case referred to medical 26.Place of	Death (Check on	1 Yes 2	No 1	Yes 2 No
Vital hysician: this certif	o Be	20. True date relation to medical	hor:		esidence 6 🗸 Ot	her: Scene
J of Jing P After funera	li li	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury a 1 Yes	at Work? 2	8d. Describe ho	w injury occurred	
ivisior or Attenc after death Director:	icati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office built				Rural Route Number, City
Divis spital or At hours after d ineral Direct y filled in by	Certification:	4 Homicide determined (Specify)		or Town, Sta	ute)	
Divis  To the Hospital or / within 24 hours after To the Funeral Dire completely filled in I	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do	and place, and d eath occurred at t	ue to the cause( the time, date ar	(s) and manner as s nd place, and due to	stated. the cause(s)
Co 1 kir J	Me	29b. Signature and title of certifier 29c. License n			29d. Date signed (	Month, Day, Year)
		O.C.M.	E		May 11, 2010	
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		<del></del>	
S Regis	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature A. Sauke				
Negis	JICIU	CITI - LUIN JAMES - JA. PARA				

10-03618 Steven Dennis Jobe

lease Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of He	alth and Mental Hygiene

		- For State Registrar			Certi	ficate c	of De	eath				Reg. N	0.		
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of De  Month  Day  Year  1.550 ber						3. Time of Death 1558 hrs							
		4a. Facility Name (if not institution, give street and number)  14917 Finegan Farm Drive  4b. City, Town, or Location of Germantown					of Death			4c. County o Montgon					
Funeral Director		5. Social Security Number 220–48–1559	umber 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.					8. Date of I			Foreig	hplace (State or n Washington untry) D.C.			
	Ŀ	Usual Residence of Decedent													10d. Inside City Limits
w any		10a. State 10b. County		10	c. City, To	own or Loca		or ro							1 Yes 2 X No
daryland 28a-f show	ğ		gomery			Darn		Zip Code				10a C	itizen of Wh	at Cour	
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 14917 Finegan	Farm Dri	WA			101.	2087	74			-	ited S		
vith th		11. Marital Status	12. Was De		er in U.S.			cedent of Hisp	panic Orig				14. Race	- Ameri	can Indian, Black,
leath v r item	Funeral	1 Never Married 2 X M		2	No	lf	Yes, s	pecity Cuban,	Mexican	, Puerto F	Rican, etc.)		White	, etc.	***
after d	D F		orced If Yes, Give Ye or Dates:		nam	1		2X No				Lin	Specify:		White
hours	Pg.	15. Decedent's Education (Spe		de comple 1-4 or 5+)	eted) 1			sual Occupati f working life.					. Kind of Bus		ndustry
36 hin 72 e. than than	ple	Elementary/Secondary (0-12)	College (			Pres	ider	nt/CEO					anagem	-	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle	, Last)					1					en Surname)		-
21215-00 uld be filed wit Mental Hygien marked other	å	William Theodo				(0) 11 3		Iress (Street	,	_			ickson		7in Code)
nore, MD 21 ages 1 and 2 should nt of Health and Mer it: If item 27 is man other traumatic ev	- 1	19a Informant's Name/Relations MaryAnn P. Jobe													land 20874
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	ł	20a. Method of Disposition				ice of Dispo	sition	(Name of cerr	_	May	Date		c. Location -		
nore ages l ant of l other		1 X Burial 2 Cremation		rom State		matory or o		emeter	у	2010		W	ashing	gtor	n, D.C.
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	ł	Donation 5 Other S     Signature of Funeral Service	Licensee			22. R.C	Name	and Address	of Facilit	ev F	uneral	Ho	me/Bet	hes	da-Chevy
		23a. Part I/Enter the disease, or			0019	5 175	57 I	Wiscon	sin A	ve	Bethe	sda	. Marv	lan	d 20814–3501 Approximate Interval
Physician		23a. Part I/Enter the disease, or failure. List only one cause	on each line.					ode or dying,	such as c	ardiac or	respiratory	arrest, e	sriock, or rice		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Contact SI Due to (or as			or Ches									
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):										
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):										
iox 68760, eath certificate be executed e attending physician and for use as the burial - transis	a E		¬ d		_										
O, be excision	/Medical	UNPENDED	AMENDED									- 12	23d. Date of	deliven	
Box 68760, e death certificate be the attending physic ed for use as the bur		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 23c. If yes		or pregna	ncy 2 🔲 F	etal de	eath 3	Ectopi	c pregnar	псу		Month Month	-	Day Year
ox 6 ath cer attendi	Physicia		tracum	nant at tim	e of deat	_		(Specify)				ł			
by the teched f	Phy	Part II. Other significant condi			ut not res	ulting in the	under	tying cause g	iven in Pa	art I.	23e, Die	d tobac	co use contri	bute to	the cause of death?
P.C es that signed be deta	d by										1 🗆	res 2	<b>✓</b> No 3[	Prob	pably 4 Unknown
rds requir	Completed											topsy	P	rior to o	topsy findings available completion of cause of
eco he law ate has	a mo	1									pe 1 <b>✓</b> Ye	rformed s 2		leath?	es 2 No
al R ian: T certific ctor, p	BeC	25. Was case referred to medica examiner?								(Check o					
F Vit	2	1 ✓ Yes 2 No	Hospital: 1	Inpatient		R/Outpatie			Other <sub>4</sub>		Home 5		idence 6 v	_	r: Scene
ding l	ion:	27. Manner of Death  1 Natural 5 Pen		e of Injury th, Day,Year D		FOUND:	i ii ijui y		res 2.✓	_	Subject s				
Division of Vital Records, P.O. real or attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	ficat		estigation May 10 28e. Pla			1540 hrs ne, farm, str	eet, fac	tory, office b	uilding, e	tc.				er or Ru	ural Route Number, City
Dital or	Certification:	4 Homicide		Singl	e Fami	ly Home					or Towr 14917 Fine	gan Fa	arm Drive ,	Germa	antown, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C														
To To COL	Me	29b. Signature and title of certifi	and manner	sialeU.				29c. Licens	e number				_		nth, Day, Year)
		( Ataluka	relle)					O.C.I	M.E.			М	lay 11, 20	10	
		30. Name and address of person Laron Locke MD.	n who completed ca Assistant Medic				nn Str	reet, Baltin	more M	1D 2120	01				
	ate	31. Date filed (Month, Day, Year,	) 32. F	Re istrar's		9	,		, 10						
Regist		MAY I	7 2010	Deneu	a,	B. A	an	les .							
DHMH 17 Rev 1/2	001	0.00				ORIGIN	AL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** N **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign County) 8. Date of Birth Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 214-78-819 1 M 2 - F Months **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 1 Yes 2 No Funeral Director OWIE 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ō 20720 items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 12. 11. Marital Status Black, White, etc. Yes Yes 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Kureai ō 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Year or Dates 'natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me loved 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number of Bural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) AKWOOD 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date or other place 1 Burial 2 Cremation 3 Removal from State Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Horse 20794 MD 102 UTU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cirposis Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes eral Director: After this certificate has been significate in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 2 No Hospital: 2 🗀 ER/Outpatient 3 DOA 6 Other (Specify) 1 🗌 Yes **H**npatient မ 28d. Describe how injury occurred Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: njury 5 Pending investigation Natural 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director; A 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) Anya 600 North Wolfe St, Baltimore, MD, 21287 Litvak 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

10-03592 Douglas B Kevari	Sta 1- For State Registrar			tal Hygiene	2010 g. No.	1528
Physician/ Medical Examine				2. Date of Death Month May 9, 201	Day Year	Time of Death 2020 hrs
h	4a. Facility Name (if not institution, Frederick Mmorial Hos	-	4b. City, Town, or Location of Frederick	f Death	4c. County of Death Frederick	
Funeral Director	217 74 0000	. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under Months Days Hours		6 (MM/DD/YYYY) 9. Birthpla Countr	
land f show any once.	Usual Residence of Decedent 10a. State 10b. County MD Prince	George   10c. City, Tow Green	belt		1	d. Inside City Limits Yes 2 X No
vith the Maryland s 23a or 28a-f show s uotified at once.	10e. Street and Number 434 Ridge Road		10f. Zip Code 20770		og. Citizen of What Country JSA	,
fter death with 1 ?, or items 23s er must be not	11. Marital Status  1XX Never Married 2 Mar  3 Widowed 4 Divo	1XX Yes 2 No ced If Yes, Give Year 1083_2000	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,		14. Race - American White, etc. Specify: White	
Baltimore, MD 21215-0036  permit. Pages 1 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	AF Deceded Education (Capai	y only highest grade completed) 16a  College (1-4 or 5+)	a. Decedent's Usual Occupation (Give during most of working life. DO NOT		16b. Kind of Business/Indu	•
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica				s Name (First, Middle, M		
MD 212 dd 2 should be dith and Mentz am 27 s mark aumatic even			9b. Mailing Address (Street and Num 434 Ridge Road, Gr			Code)
Baltimore, Woemit. Pages 1 and 3 Department of Health Important: If item 3 njury or other traus	20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Spe	3 Removal from State 20b. Place crem	e of Disposition (Name of cemetery, atory or other place) eteran Cemetery	Date 05–18–2010	20c. Location - City or Tov Crownsville,	
Balti Permit. Departm Import injury o	21. Signature of Funeral Service L		22. Name and Address of Facility Bailey Funeral 4023 Annapolis not enter the mode of dying, such as c	Home and Cr	chorpe, MD 21 est, shock, or heart	227 Approximate Interval
/Medical	failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	n each line.  a. Atherosclerotic Cardiovaso  Due to (or as a consequence of):				Between Onset and Death
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a consequence of): c.				
स्त्र है। ज		Due to (or as a consequence of):  d.				
00, e be execut ysician and burial - tra	UNPENDED	AMENDED  23c. If yes, outcome of pregnance			23d, Date of delivery	
Division of Vital Records, P.O. Box 68760, othe Hospital or Attending Physician: The law requires that the death certificate be executed the Euneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transcript of the funeral or transcript or the funeral director.	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkr	1 Live birth 4 Pregnant at time of death		pregnancy	Month Day	Year
P.O. E res that the c signed by the be detached by by by detached by the detached by the detached by Ph	7	ns contributing to death but not result	ring in the underlying cause given in Pa		bacco use contribute to the	
Division of Vital Records, P.O. B. tal or Attending Physician: The law requires that the de is after death.  *al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached for entification: To Be Completed by Physerification: To Be Completed by Physerial and the partial carriers and the properties of the physerial carriers and the physerial carriers are also be properties.		7		24a. Was autop perfor	sy prior to com rmed? death?	sy findings available pletion of cause of 2 No
fital Fisions: Sicions: 25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ✔ ER	26.Place of Death  Outpatient 3 DDA Other		Residence 6 Other:		
on of V ading Phys th. r: After thi re funeral di	27 Manner of Dooth	28a. Date of Injury (Month, Day, Year)	o. Time of Injury 28c. Injury at Work	? 28d. Describe f	now injury occurred	
Division o o the Hospital or Attending ithin 24 hours after death of the Funeral Director: Afte ampletely filled in by the fune golical Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide	gation not be 28e. Place of Injury - At home	farm, street, factory, office building, et	c. 28f. Location (\$ or Town, \$	Street and Number or Rural itate)	Route Number, City
Division  Othe Hospital or Attendary  Othe Hospital or Attendary  Othe Runeral Director:  ompletely filled in by the	20a Certifier	rsician: To the best of my knowledge, of iner: On the basis of examination and/of and manner stated.	death occurred at the time, date and plant investigation, in my opinion, death oc	ace, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the c	ause(s)

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Da

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 10, 2010

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 18 per Fh g903 5/17/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1001 MARTINA 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🕱 F Months 253-28-4446 89 01-02-1921 Director Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location sa or 28a-f show t be notified at 10a. State 10d. Inside City Limits 1 □Yes 2 No Director Maryland Ellicott City Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3004 North Ridge Road Apt#H217 21043 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>م</u> Specify. 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filk iment of Health and Mental H tant: If item 27 Is marked out Be Charles Jamison Hall Lizzie Chapptear Chapplear ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Morgan Department of Health Important: If item 27 any Injury or other tr (Niece) 10730 Evening Wind Court Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XI Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Virginia Veterans Cemetery: 5-21-2010 Amelia, Virginia 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 21. Signature of Juneral Service License un 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL INFARLTTON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, buy, and in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate has Yes 2 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury 5 Pending of Funeral Director: A Funeral Director: A solution of the funeral place of the funeral of the f 1 ☐ Yes 2 ☐ No investigation death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

AMIT DEJAI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

7804 ARBOR GROVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

M.D

DR - APT. 440 HANOVER, MD

within 24

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29c. License number

D69106

29d. Date signed (Month, Day, Year)

2010

Physician/

Medical Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Month Da May 9, 2010 1836 hrs FEAN UTABETU 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Rosedale **Baltimore County** Franklin Square Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Country) MD 02-25-1962 LNKNOWN 1 M 2 F Usual Residence of Deceden 10a. State 10b. County Oc. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MDDALT IMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 346 21220 **DHPOEDARK** Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black Armed Forces Never Married 2 Yes Specify: White f Yes, Give Year or Dates: 1 Yes 2 No specify: 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOME OWN Homemaker 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) AFRAN AMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Schoolhouse KOAD 21237 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State CREMATOR 05-13-2010 BAUTIMORE reul Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Lie 2134 Willaw BAUX1 MD DIBBD SHIDN 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and failure. List only one cause on each line. Death Cocaine and methadon eintoxication Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Di if any, leading to immediate cause. Enter Underlying Cause

Physician /Medical Examiner

Pages I and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, MD 21215-0036

t: If item 27 is marked other than other traumatic event, the Medical

attending physician and or use as the burial - transi The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Funeral Director:

Certificat

Medical

events resulting in death) Last	Due to (or as a consequence of):
	d
X UNPENDED	AMENDED, PII, 27, 2
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknow	23c. If yes, outcome of pregna  1 Live birth  4 Pregnant at time of death  9 Unknown
Part II. Other significant condition	ns contributing to death but not resu
Cirrhosis of	liver
25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1
27. Manner of Death	28a. Date of Injury (Month, Day, Year)
	events resulting in death) Last  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unknot  Part II. Other significant condition  Cirrhosis of  25. Was case referred to medical examiner?  1 V Yes 2 No  27. Manner of Death

ue to (or as a consequence of):			
ue to (or as a consequence of):			
AMENDED , PII, 27, 28a-f, per ME g904 6/3/10	TT		
23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		23d. Date of delivery Month E	day Year
ontributing to death but not resulting in the underlying cause given in Part I.  Ver		cco use contribute to	the cause of death? ably 4  Unknown
	24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of
26.Place of Death (Check only	one)		

		1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26.Place of De	eath (Check only one)
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other	4 Nursing Home 5 Residence 6 Other:
27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury at V	Nork? 28d. Describe how injury occurred
1 Natural 5 Pending	1E4 5 /0 /10	2X No unk
2 Accident Investigatio	29a Place of Injury. At home form street factory office buildin	g, etc. 28f. Location (Street and Number or Rural Route Number, City
3 Suicide 6 X Could not b	be [	or Town, State) 346 Shagbark Rd Baltimore, MD

O.C.M.E.

9a. Certifier	1 Certifying Physic	an: To the best of my knowledge, death occurred a	at the time, date and place, and due to the cause	e(s) and manner as stated.		
спеск опіу эпе)	whether the time is a second of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
9b Signatur	re and title of certifier	and manner stated	29c. License number	29d. Date signed (Month, Day, Year)		

	my		,	VW 2	
00 11-	al al al an a	6		sampleted source of a	looth (Itam 22a)

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

OCME

May 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month 5 Year ZONO Physician/ LUNTZ . Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner If Under 24 Hrs Hours Min. 9. Birthplace (State or Foreign Country) MISSOUR 7. Age (In yrs. last birthday) 8. Date of Birth Sèx 1 M 2 □ F **Funeral** Months (Month, Day, Y 3 Director 10d. Inside City Limits 28a-f shov 10c. City, Town or Location death with the Maryland Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 🗹 No 10g. Citizen of What Country? 10f. Zip Code 6 10e. Street and Number 2115 items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No "natural", or ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify 3 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any in]ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2010 FORREST 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility (1924 YOKK)

23a. Part 1. En a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or has failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate OCAMOIAL Physician/ disease or condition Medical resulting in death) Examiner Esquartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last RTRIGHTENDEMIA To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not requiting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform To the Funeral Director, After this certificate completed filled in by the funeral director, page 1 ☐ Yes 2 X No 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 Natural 2 No Investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature of certifier 29c. License number 30133 113/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 PAPER MILL ROAD BALTIMORE, NO 21131 arnelly MD

State Registrar 31. Date filed (Month, Day, Year)

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MIL 1936 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARTURN HARFURN HOSPITAL Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Pay Year) 9. Birthplace (State or Foreign **Funeral** 1 **V** M 2 □ F Hours Months 237-28-7492 Min. gland Director 60 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: I frem 27 is marked other than "natural", or items 23a or 28a-1 sho important: I frem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ti more 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Be ather's Name (First, Middle, Last 18. Mother's Name (First, Middle, ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, mace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Location - City or Town, State Date 20c. 1 Surial 2 Cremation 3 Removabrom State 5 Other (Specify) 21. Signature Fineral Service Liv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ LUNG CANZER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ☐ Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed No 2 No 1 🗌 Yes 25. Was case referred ≯6 medical 26. Place of Death (Check only one) examiner? Hospital: 2 \( \sqrt{No}\) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred ✓ Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) LAKEW 3055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HARIFURD (8) , HAVEE DE GRACE JATIAZGH 31. Date filed (Month, State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death\_ Physician/ ance Medical 4a. Facility Name (if not institution, give street and number, 4b. City Town, or Location of Death 4c. County of Death Examiner andallstown Baltimore laser Northwest 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday Funeral 1 □ M 2 🔀 F 243.80.2163 Months Hours Min Country) NC Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Completed by Funeral Director Baltim ore MO 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ıral", or items â 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: Specify: Back 3 Widowed 4 Divorced "natural" the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Healthcare Nurse Aid 12th grade Zuens Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ tardy Mites Estella Brunson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Ellame Mites 4004 Primrose 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory) or other place) 20c. Location - City or Town, State 1 = 1 Department of Important: If any injury or 12010 Balto MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Greene Funeral services 22. Name and Andress of Facility Vau Road landallotown MD21133 23a. Part 1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death d ailure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ cei Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and be detached for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ retail CC.
☐ Pregnant at time of death
☐ Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 1 Yes 2 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Inknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perfor death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: ė 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my and investigation. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

29c. License number

## State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month Miller Wimebert Theodore 16 Medical 05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at Salisbur Wi comico the Lake 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Days Hours Min Months 09/28/1936 Maryland Director 219-32-2705 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director Dagsboro Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a or the Medical Examiner must be with 1 Funeral 19939 U.S.A. 31182 West Ocean Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married 1959 þ 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 ☐ Divorced 1961 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Teacher/Counselor School permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 Is marked othe any injury or other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Borchers David W. Miller, Sr. မ 19a. Informant's Name/Relationship (Type, Print) Cecelia Schafer (Step-Daughter) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Liberty Court, Edgewood, Maryland 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/19/2010 4 Donation 5 Other (Specify) Gardens of Faith Baltimore, Maryland 21. Semilure of Fundry S 22. Name and Address of Eruzozinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Immediate Gause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 🛣 No Month Pregnant at time of death the s ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe I be d þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform After this certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \sum \) Yes 2 \( \sum \) No Other: 4 Nursing Home 5 Residence 6 K Other (Specify) Hospital ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No within 24 hours after death. To the Funeral Director: All completed filled in by the fu death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 M Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Interval Between

Onset and Deat

mont

Day

29d. Date signed (Month, Day, Year)

05-16-2010

Year

1 🗆 Yes 2 🔀 No

3:30 AM

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

only one

29c. License number

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

29505

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 12, Physician/ 2010 5:03 Рм Marjorie Taylor Miller Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Bethesda Carriage Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Min. Nov. 7 F914 Washington, D.C. 95 578-03-3726 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Chevy Chase Maryland Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20815 United States 8100 Connecticut Avenue 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give ģ White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 N Divorced Completed Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Warren ၀ Percy E. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20008 3000 Tilden Street, N.W., Washington, D.C. Penelope Hansen/Daughter or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery
Control Department of Important: If it any injury or o once. May 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 2010 4 Donation 5 Other (Specify) <u>Crematorium,</u> Bethesda-Chevy Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Se vice Licensee 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ week Pneumonia resulting in death) Medical Due to (or as a consequence of): **Examiner** week Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be detended. Completed by Chronic Obstructive Lung Disease 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Failure to Thrive Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 K No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes Other: 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at s after death. 28d. Describe how injury occurred Certificate: 1 🖺 Natural work? 1 Yes 2 No 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) May 13, 2010 ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Raman R.

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

Tuli, M.D. 10810 Darnestown Road #202, Gaithersburg, Maryland 20878

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Mar	yland / De				nd M	lental Hy	giene	901	0	-	200
			Registrar  1. Decedent's Name (First, Middle	Last)	-		ertificat	e ot De	eatn		2. Date of Dea	Reg. No	411	J	0.4	189
	Physicia Medic		THOMAS		ÆADOW	S SR.					Month	Da			. Time of [ る: 05	
	Examin		4a. Facility Name (if not institution,	•	nber)		4b. City	Town, or L	ocation of	Death	1017		County of De		- (0)	
· personal			Union Memorial Ho	•				Balti	more				N/A			
	Funeral Director		5. Social Security Number 236-66-9026	6. Sex 1 🗷 M 2 □ F		n yrs. last birthda 65 Yrs	Months	Days	Hours	Hrs. Min.	8. Date of Birt Nov. 15	h (* 194	9. B Ma	irthplace ountry) rylan	(State or d	Foreign
	nd now st	ī	Usual Residence of Decedent  10a. State 10b. County		10	Oc. City, Town or	Location							10-11		. 1
	anylar ta-fst tried	ecto	Maryland N/A	1	'`	-	Brooklyi	1							Inside City	
	or 28	I Dir	10e. Street and Number				10f. Zi	Code				10g. Cit	izen of What C			
	s 23a sust b	Funeral Director	3910 Brooklyn Ave	enue				21	.225				U.S.A	•		
36	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 ☐ Marri</li> <li>3 ☐ Widowed 4 ☒ Divorced</li> </ul>	If Yes, Giv	orces? 2 ื No /e		3. Was Deced If Yes, spec	offy Cuban,	Mexican, F	n? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: <b>W</b>		ndian,	
21215-0036	hours natura ical E	Completed	15. Deceden	Year or Dates t's Education		16a. De	cedent's Usu	al Occupati	ion				ind of Busines		21	
215	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)													•		
2	Elementary/Seconday (0-12) College (1-4 or 5+)  Dec 2												S.X. Kai	Lroad		
Maryland	d be filed Mental Hyg arked oth	To B	17. Father's Name (First, Middle, La Hersel T. N	ast) <b>leadows</b>				1	8. Mother's		(First, Middle, I	Maiden S rely	Surname)			
	and 2 should be file Health and Mental H tem 27 is marked o ther traumatic eve		19a. Informant's Name/Relationsh Meredith L. Collins		er)	19b. M 80	ailing Address Bradfo	(Street and ord Ave	nue, A	or Rural rnolo	Route Number 1 Marylar	City or d	Town, State, Z 1012	ip Code)	)	
Baltimore,	- 4 E 0		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation	3  Removal from			rematory or c	ther place)			ate		cation - City o			
Ē	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funer → rvice Li	pecify)	للز	Bayview			Mar				timore, l			
Ba	perm Depa Impo any i		This	190	M		437 East	Patap	SCO AV	enue.	lly-Polyn , Baltimo	re, r	Funeral l Yaryland	lome 1 2122	P.A. 5	
			23a. Part 1. Enter the disease, or on hook, or heart failure. List or	complications that only one cause on ea	caused the ich line.	e death. Do not e	nter the mod	e of dying,	such as car	rdiac or	respiratory arre	est,		Inte	roximate rval Betwe	een
· ·	Inysician/ Medical		l rediate Cause (Final ease or condition resulting in death)		chen		rdio m	gar	My					Ons	set and De	eath
	Examiner		<b>5</b>	Due to (	or as a co	onsequence of):		a.		1				ر ا		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (	or as a co	onsequence of):	(4) (4) (4) (4) (4) (4) (4) (4) (4) (4)							1 2	- doi	47
	cuted ind transit	Examiner	Cause (Disease or iinjury that initiated events	o. mili			ilune							2	day	4
	cate be executed physician and the burial-transit	崩	resulting in death) Last	Due to (	orasa co	onsequence of):									/	
20/	cate to physical street	edical		d	-											
BOX 68	certifi anding use a	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of p	regnancy Fetal death	□ <b>5-1</b>						23d. Date of de	elivery		
90	he death y the atte ched for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at tim		Other (sp						Month	Day	Yea	ar
7. Ö.	that the	by PI	Part II. Other significant condition	ns contributing to de	eath but n	ot resulting in th	e underlying o	ause given	in Part I.		23e. Did tol	bacco us	se contribute t	o the cau	use of dea	ith?
ds,	equires										1 □ Y	es 2 [	□ No 3 🔼 I	Probably	4 🗌 Ur	ıknown
Vital Records,	law re has be e 2 sh	Completed									24a. Was a autops	sy		itopsy fir complet	ndings ava	ailable use of
2	icate		25. Was case referred to medical								1 Yes	med? 2 🔀 No	death?	s 2 💢	,No	
	rsicial s certi: directo	To Be	examiner?  1  Yes 2  No	Hospital:	Innationt	2  ER/Outpat	iont 2 🗆 DO	Other:	of Death (					75.1		_
0	ig Phy ter this neral c		27. Manner of Death	28a. Date		28b. Time	of 2	3c. Injury at		$\neg$	e 5 Reside			cify)		
0	tendir leath. or: Af the fu	iica I	1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could n	ation	n, Day, 10	.a./	М	work?	s 2 🗆 No	0						
JIVISION	al or Att s after d I Direct d in by	Certificate:	4 Homicide determin	28e. Place	of Injury - ng, etc. (S <sub>i</sub>	At home, farm, s pecify)	treet, factory	office		28	Bf. Location (St City or Town		Number or Ru	ıral Route	e Number,	;
_	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L Medical Ex	Physician: To the basi aminer: On the basi Nurse Practioner: T	is of exam.	ination and/or inv	estigation, in r	ny opinion, i	death occur	rred at th	ne time date an	d place	and due to the	Cause(s)	and mann	er stated.
	Vithi Von		29b. Signature and title of certifier				29c	License nu	umber	_			signed (Mont		'ear)	$\neg \neg$
			) laten					T243	3894	16		Mo	xyoll,	201	0	
	101		30. Name and address of person w	ho completed caus	e of death	(Item 23a) (Type Memo r	Print)	ospi	tail	Be	atimor	e,M	10,21	218		
	State Registra	~	31. Date filed (Month, Day, Year)	7 2010 <sup>32. Re</sup>	egistrar's S	Memo r Signature	par	lad.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give **Examiner** 4 venue 9. Birthplace (State\_or Foreign **Funeral** Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Kes 2 No 10f. Zip Code 10g. Citizen of What Country? 2121 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. W s Decedent Ever in U.S Race - American Indian 11. Marital Status ned Forces Black, White, etc. 2 No 1 Never Married 2 Married Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗙 No "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DD NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Be ည 19b. Mailing Address (Street and N f Health aitem 27 Baltimore, Burial 2 Cremation 3 Removal from of Disposition Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 5 injuny Donation 5 Other (Specify) Signature of Funeral Service Licenses MO1553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 | Ilnknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Dunknown should peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed death 2 1 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica Division of Vital Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? ပ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Sesidence 6 Other Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After work? 1 Netural 5 Pending injury 2 🗆 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The death of examiner. The bests of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one 29d. Date signed (Month, Day, Year) 2010 May 12 eted cause of death (Item 23a) (Type, Print) Raven Blue Loch 32. Regi rar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan	•		nt of H		and M	ental Hy	giene	•	
			Registrar  1. Decedent's Name (First, Middle, Last)	<u> </u>		Cer	lilica	ie Oi L	Jean		2. Date of De	Reg. No ath	L U I U	3. Time of Death
	Physicia Medi		Doris Leona Pa	almer							May	13 <sup>Da</sup>	<sup>ay</sup> 201 <sup>Y</sup> 0 <sup>ar</sup>	11:47 p <sub>M</sub>
	Examir		4a. Facility Name (if not institution, give st Stella Maris	reet and number)		-	_	, Town, or OWSOI	Location o	of Death		40	Balti	
	Funeral Director		217 22 0310		e (In yrs. I 33	ast birthday) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April	th ay, <i>Year)</i> 3 19		thplace (State or Foreign untry) MD
	Aaryland 8a-f show tified at	rector	Usual Residence of Decedent  10a. State	e	10c. Cit	y, Town or Lo								10d. Inside City Limits
	with the N s 23a or 2 rust be no	<b>Funeral Director</b>	10e. Street and Number 1152 Monkton Road					ip Code 21111				10g. Ci	itizen of What Co	ountry?
9003	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fur	1 Never Married 2 X Married 3 Nidowed 4 Divorced	2. Was Decedent   Armed Forces? 1  Yes 2  If Yes, Give Year or Dates.			fYes,spe 1☐Yes	ecify Cuba 2 XNo	n, Mexicar Specify:	, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc. ite
21215-	vithin 72 ho iene. r than "na the Medic	Comple	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		5+)		kind of w O NOT u:	ual Occupa ork done d se retired)	ation <i>furing m</i> osi	t of working	9		Gind of Business	Industry
Baltimore, Maryland 21215-0036	d be filed v Mental Hyg arked othe aric event,	To Be	17. Father's Name (First, Middle, Last) Jessie Hall			,					First, Middle, Ruth			-
, Man	and 2 shoul Health and I tem 27 is ma		19a. Informant's Name/Relationship (Typ Sharon Colison (da								on, MD		r Town, State, Zij . 11	o Code)
timore	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗀 F 4 🗀 Donation 5 🗀 Other (Specify)	Removal from State		Place of Dispo cemetery, cren est Law	natory or n Me	other plac moria	al ¦.	5-22-		Marr	ocation - City or	11e, MD
Ball	permit Depart Impor any in	ki ji	21. Signature of Funeral Service Licenses  Pagy Haight D	perbent		P	0.0.	Box 1	195 S	ykesv	ille,	MD 2	Home & 21784	Chapel
	Physician/ Medical	S 19	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)			h. Do not ente	0		g, such as		F1C	rest,	<i>g</i>	Approximate Interval Between Onset and Death
	Examiner usit	Examiner	Sequentially list conditions, if any leading to min adiate cause. Enter Underlying Cause (Disease or injury	Due to for se	a coneaci	ience of):								
09	cate be executed physician and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):								
. Box 687	ath certification of the second of the secon	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	aldeath 3	Ectopic Other (s	pregnanc	у				23d. Date of de Month	livery Day Year
ls, P.O.	uires that the dean signed by the a		Part II. Other significant conditions con	tributing to death b	out not res	sulting in the u	ınderlying	cause giv	en in Part	I.				the cause of death?
Record	rsician: The law require s certificate has been si lirector, page 2 should	Completed by									24a. Was auto perfo		prior to	topsy findings available completion of cause of
ital	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 💢 No	ospital:				Othe	ace of Dear					
of V	ng Phys ter this neral di	ite: To	27. Manner of Death  1 X Natural 5 Pending	1 ∐ Inpati 28a. Date of inju (Month, Da	iry	ER/Outpatier 28b. Time of injury		28c. Injury work	4 ∠Nu ∕at		ie 5 🗌 Resi 3d. Describe I		Other (Spectry occurred	ify)
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul			M eet, facto	1 🗆	Yes 2 🗆	-	Bf. Location (S City or Tov			ral Route Number,
_	he Hospit: in 24 hours he Funera ipleted fille	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine only one) 3 X Certifying Nurse	er: On the basis of e	xaminatio	n and/or invest	tigation, ir	my opinio	n, death od	curred at the	ne time, date a	and place	e, and due to the	cause(s) and manner state
	To t with vith com		29b. Signature and title of certifier				29	lc. License	number	25	9	29d. Da	ate signed (Monti	1, Day, Year)
			30. Name and address of Person who com MARIAM BAKIR, CR			23a) (Type, F		ROAT	D TT	MONIT	M, MD	2109	93	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistra		ture	n Ka				, <del></del>			

DHMH 17 Hev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marcus Rembe	rt	State of Maryland 1-For State Registrar		artment o ertificate o		Mental H	, ,	Reg. No. 2 (	10 1529
Physici Medical Exam		Decedent's Name (First, Middle,Last)	mbo	r+		-	2. Date of De Month	eath Day Ye	3. Time of Death
ijodiodi Exam		Marcus Sylvester Re	embe		4b. City, Town, or Loc	cation of Death	May 4, 2	010 4c. County	0505 hrs
		3403 Ingleside Avenue			Baltimore				
Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 3 - 90 - 6445	e (In yrs. 46	last birthday) Yrs	Months Days	If Under 24Hrs Hours Min.	8. Date of E		9. Birthplace (State or Foreign MD Country)
		Usual Residence of Decedent							
and show any nce.		10a. State 10b. County MD Baltimore		y, Town or Locat .tonsvi					10d. Inside City Limit 1 Yes 2 N
arylanc 8a-f sh at onc	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
h the Maryland 3a or 28a-f sho		1000 Craftswood Road			21218			USA	,
ath with	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?			s Decedent of Hispar es, specify Cuban, M				e - American Indian, Black, ite, etc.
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	1	Yes 2 X No s	pecify:		Specify:	Black
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	ted b	15. Decedent's Education (Specify only highest grade com		16a. Deceder during m	t's Usual Occupation ost of working life. DC	(Give kind of w	vork done red)	16b. Kind of B	usiness/Industry
036 thin 72 ne. • than " [edical]	Completed	Elementary/Secondary (0-12) College (1-4 or s	<del>+</del> )	Retai	1 Food	Servi	ce	Food	Service
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)  Elmore Simon Rembert		-L	18.M	Mother's Name	(First, Middle,	Maiden Surname tine	e) Smith
Elmore Simon Rembert    Mable Ernestine Smith									
MD nd 2 sho alth and m 27 is	Ċ	Gail Pauline Cook  20a Method of Disposition		1000	Craftsw	ood Ro	oad Ca	tonsvi	11 <sub>21218</sub>
Baltimore, ML permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other traum		1 XBurial 2 Cremation 3 Removal from Sta	te	crematory or oth			Date 19/10		- City or Town, State  WOOD MD
altim mit. Pa partmen portant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Influence	C:		wn Cem				herfordFS PA
		tatuen Jahmoie		! 2	2431 East	t Oliv	er St	Baltin	more MD21213
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.							Between Onset and
Examiner		$\begin{array}{c} \text{Immediate Cause (Final disease} \\ \text{or condition resulting in death)} \end{array} \text{ a.} \underbrace{\begin{array}{c} \text{Mixed } \text{dru} \\ \text{Due to (or as a conservation)} \end{array}}_{\text{Due to (or as a conservation)}}$	gs ( quence o	Uniorai fintoxi	azepoxide, cation	, Topir	amate)	and Alc	ono L Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence u	fy.		-			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a conse	nuence n	ıf):					
ecuted and transit		d.	1440000						-
50, e be executed ysician and burial - transit	edical	UNPENDED AMENDED 23a,27,2	8a-f	,per ME	G904 6/3/	/10 TT			
OX 6876 eath certificate attending phy for use as the t	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom		2 Fet	al death 3 E	Ectopic pregnar	ncy	23d. Date of Month	f delivery Day Year
Box 6876 e death certificate the attending phy ed for use as the 1	hysici	1 Yes 2 No 9 Unknown 9 Unknown	me of de	eath 5 Oth	ner (Specify)				
P.O. Ess that the d	by Ph	Part II. Other significant conditions contributing to death	but not re	esulting in the u	nderlying cause given	n in Part I.			ibute to the cause of death?
ords, P.C.  w requires that s been signed I should be deta							1 Ye		Probably 4 Unknown  Were autopsy findings available
e law re	Completed					<del></del>	autop	osy pormed?	orior to completion of cause of death?
Vital Rec ysician: The his certificate director, page	o l	25. Was case referred to medical			26.Place of D	eath (Check or	1 Yes	2 No 1	Yes 2 No
f Vita		examiner?  1 V Yes 2 No  Hospital: 1 Inpatier		ER/Outpatient		· _ runoning		Residence 6	
on of tending Pheath.	cation:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injur (Month, Day,Ye	ar)	28b. Time of In	1 Yes		28d. Describe unk	how injury occurr	ed
Division of Vital Records, tal or Attending Physician: The law requirers after death.  Tal Director: After this certificate has been sited in by the funeral director, page 2 should be	tifica	Suicide Could not be		Fd 0500 ome, farm, street	nr b , factory, office buildin	ng, etc.	28f. Location (	Street and Number	er or Rural Route Number, City Ingleside Ave
Di ospital hours a uneral I	Certific	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my		sidence			<u>Baltimo</u>	ore, MD	
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	Check only one)  2 Medical Examiner: On the basis of exam and manner stated.							
H 3 H 8	×	29b. Signature and title of certifier		1	29c. License nur			7/1	ed (Month, Day, Year)
or perd		30. Name and address of person who completed cause of de	ath /ltom	232)	O.C.M.E.			May 4, 201	0
		Zabiullah Ali, M.D. Assistant Medical Exa		/ .	Street, Baltimor	re, MD 212	01		
Sta Regist		31. Date filed (Month, Day Year) 7 2010 32. Figistrar:	Signatur	ref ha	Kel				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of Ma	aryland /	•	artment of H <i>tificate of D</i>			IENE eg. No. 🤈 🏳	110	15203
			Registrar  1. Decedent's Name	(First, Middle, L	ast)			timodico or B	-	2. Date of Deat	h fees to		3. Time of Death
	Physicia Medic		John R	ueckert						Month May 13,	Day 2010	Year	11:00 p <sup>M</sup>
	Examin		4a, Facility Name (if r	not institution, g	ve street and number)			4b. City, Town, or		•		ty of Death	
	_		_		sisted Livir		to the offers	Ell:	icott Cit		Ho	oward	-land (Otata and Tanaha)
	Funeral Director		5. Social Security Nu 017–18–22	274	Sex 1 ☑ M 2 ☐ F	e (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Birth 04/19/1	923	Goun MA	place (State or Foreign htry)
рL	now at	١	Usual Residence of I 10a. State	Decedent 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
arylar	a-f sl	Director	ID	Bonniev	<i>r</i> ille		Ida	ho Falls					1 🗌 Yes 2 🛛 No
the M	or 28 e not	ᄒ	10e. Street and Num	ber				10f, Zip Code		1	0g. Citizen of	What Cour	ntry?
death with the Maryland	s 23a ust b	Funeral	3778 East	Deer (	reek			8	83401		Unite	ed Sta	ates
death	item ner m		11. Marital Status		12. Was Decedent E Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ	
after	al", or xami	d by	1 Never Marrie		If Yes, Give	No	1	☐ Yes 2 🙀 No	Specify:		Specia		
7.27.5-0036 thin 72 hours after	natura ical E	Completed		15. Decedent's	Year or Dates.  Education	16	l Ba. Deced	lent's Usual Occupa	ation		16b. Kind of	Business In	dustry
<b>213</b>	e. nan "r Med	티	(Specification (Speci	, , ,	grade completed) College (1-4 or 5	+)	(Give I life. D	kind of work done do O NOT use retired)	uring most of work	ing			
with L	17. Father's Name (First, Middle, Last)  John M. Rueckert  19. Informant's Name/Relationship (Fuce, Print)  19. Mailing Address (Street and Number or Burel Boute Number City or Town, State												<del>1</del>
and e file												ne)	
												State Zin (	Codel
<b>Sa</b>	alth an 27 is r trau		John M. H	·		"		B East Dee					
<b>e</b> ,	of Heg		20a. Method of Dispo		[] a 11 a 1	20b. Place	of Dispo	sition (Name of natory or other place	9)	Date	20c. Location	a - City or To	own, State
Page	ant: If		1 ☐ Burial 2 D 4 ☐ Donation	Cremation 3     Specific Control Specific Contro	Removal from State ecify)		-	Crematory		′18/201¢	Balt:	imore,	, Maryland
<b>Baltimore</b> , permit. Page 1 and	Department of Healt Important: If item 2 any injury or other once.		21. Signature of Fun	eral Service 10	ensee a day	$\overline{}$	22 41	Name and Addres  O7 Wilker	s of Facility Hu	bbard Fu Baltin	neral	Home,	, Inc.
			23a. Parv 1. Enter the	ne disease, or co	omolioations that caused y one cause on each line	the death. Do	not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between
	sician/		Immediate Cause (F disease or condition	inal	. /	Alkenos	cleu	otu Car	deoversa	clar K	esery	0,0	Onset and Death
	Medical xaminer		resulting in death)	4	Due to (or as a	consequence	e f):	otk Car inced	Dance	tic			
		er	Sequentially list cor	nditions,	b. Due to (or as a			meeo	Demen	49		_	
ted	ınsit	Examiner	cause, Enter Underl Cause (Disease or ii	lying injury			,-						
certificate be executed	physician and the burial-transit	EX	that initiated events resulting in death) L		C. Due to (or as a	a consequence	e of):						
oate be	nysicia ne bur	edical			d								
<b>587</b> ertifica	ling pl		IF FEMALE:		22 o If you guitagma	of prognancy				•			
<b>BOX C</b>	attend for us	Physician/M	23b. Was decedent p in the past 12 n	nonths?	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal de		Ectopic pregnancy Other (specify)	у			Date of deliv Month	rery Day Year
ne de	y the a	hysid	1 Yes 2 9 Unknown	l No	9 Unknown	t lime of death							
that th	ned by deta	by PI	Part II. Other signifi	cant condition	s contributing to death b	ut not resultin	g in the u	inderlying cause giv	en in Part I.				he cause of death?
dS,	en sigr uld be									1 🗆 Ye	es 2 No	3 🗌 Pro	bably 4 🗆 Unknown
<b>Kecords,</b> The law requires	as bee 2 sho	Completed								24a. Was ar	sy .	prior to co	ppsy findings available empletion of cause of
The L	ate h page	Sol								perform	med? 2 No	death?	2 🗆 No
ician:	certific ector,	8 B	25. Was case referre		Hospital:			Othe	ace of Death (Chec				Asserted hus
Phys	r this eral di	은 ::	1 ☐ Yes 2 27. Manner of Death		28a. Date of inju		. Time of	nt 3 🗆 DOA	4	ome 5 Reside	-		y) 1755 CALO 100
on C	ath. r: Afte e fune	icat	1 Natural 2 Accident	5 Pending Investiga	(Month, Day	, Year)	injury	M 1 🗆	? Yes 2□No				
Division of Vital tal or Attending Physician:	rector by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		ury - At home,	farm, str	eet, factory, office		28f. Location (St. City or Town		ber or Rura	l Route Number,
ital o	urs aft ral Dil lled in				1 ()								
Hosp	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2	☐ Medical Exa	hysician: To the best of aminer: On the basis of ea lurse Practioner: To the	xamination and	d/or invest	tigation, in my opinio	n, death occurred a	t the time, date an	d place, and c	due to the ca	ause(s) and manner stated.
To the	within Fo the compl	Σ	only one) 3 29b. Signature and t		1	best of thy kild	owiedge, t	29c, License	number	ze, and due to the	9d. Date sign	ed (Month,	Day, Year)
	21.0		•	50	ane			D30	0641		May	- 14	2010
4)			30. Name and addre	0 1	no completed cause of d	eath (Item 23a	a) (Type, F	Print) 201/pl Mar	le Road	d Ball	more	Mayle	Day, Year) 20/0 And 2/22/
	Sta Registr		31. Date filed (Month			ar's Signature	A	barker	, 2000	7	• • • • • • • • • • • • • • • • • • • •		
				17 24 1 1	CUIU THE								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Christiane G. Rodriguez Day 2010 May 9:45 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore County Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 F Months Days Hours Min Director 227-86-6326 Belgium Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Harford County Abingdon 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1027 Searay Court 21009 United States items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ò Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify. "natural", White 3 Divorced 4 Divorced Specify: the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Home Maker Own Home 09 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leon Lesire Catherine Vigneron 19a. Informant's Name/Relationship (Type, Print) (Husband) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felix L. Rodriquez-Iturrino 1027 Searay Court 21009 Abingdon, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel and May 17, 2010 (Harford Co.) 4 Donation 5 Other (Specify) Forest <u>Hill</u>, Maryland Cremation Services Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. Jeffrey L. Gair,Sr. 2325 York Road Timonium, Maryland 23a. f at 1. Erner the Visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ monacy Sea disease or condition resulting in death) Monic PAN Medical Due to (or as a consequence of): Examiner Succeentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of): bunial-1 physician Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month Day Year ned by the a 1 | Yes 2 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be c 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 autopsy performed Yes Yes ☑ No Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the bests of examination and/or investigation, in my opinen, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗍 only one) 29b. Signature and title of certifier 29e. License number 29d. Date signed (Month, Day, Year) Ou, smanne

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

o

Records,

Division of Vital

6701 N.

Charles o

M 71204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

works

31. Date filed (Month, Day, Year)

10-03564

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eroi	me Simmon		State of Maryland / Department of Health and Mental Hy  1- For State  Certificate of Death		2010	15295
	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Re 2. Date of Deat	g. No. h	3. Time of Death
Med	lical Exami		JEROME SIMMONIS	Month May 8, 201	Day Year 10	2255 hrs
The state of the s			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	i	4c. County of Death	
			900 Blk of North Hill Road Baltimore	To Day of Bird	/V/97	Ab-1 (Citate - F
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	<b>−</b> 1		thplace (State or Foreign untry)
	Director		247-31-0598 1 M 2 F 34 Yrs.	DAD1.1	9,19/2 7	CAROHNA
	any	ŀ	Usual Residence of Decedent  10a. State			10d. Inside City Limits
	<b>≹</b> .⊤	٦	MD BALTIMONE ESSEX			1 Yes 2 No
	Maryland 28a-f show 1 at once,	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
	th the Maryland 23a or 28a-f sho notified at once.	ă	48 1916HSEAS CT. 7127		4,7,4	<del>.</del>
	th wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
	ter dez		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: Bh	ACK
	ours af	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		16b. Kind of Business/	ndustry
	36 thin 72 ho te. than "ns edical Ex	활	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)	7	BuilDING	A
	5-0036 led within 72 hours after death with the Maryland thygiene. thygiene "natural", or items 23a or 28a-f ship Medical Examiner must be notified at once the Medical Examiner must be notified at once	Completed	17, Father's Name (First, Middle, Last)  18. Mother's Name	/First Middle M		
	<b>←</b> ⊭ □ R □	BeC	Willie T Simmons MARY	MILKI	ROUGHS	
	D 2121 should be fi and Mental 7 is marked 11stic event,	P	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F	Rural Route Num	ber, City or Town, State	, Zip Code)
	e, MD 1 and 2 sho Health and item 27 is		CHARLOTIE A LOWERY HO NIGHSEAS CL	2分5人	1112,272	7/
	ages l an of Hea		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
		ļ	4 Donation 5 Other Specify: MT, CARMA 9-	15-10	VUNVA 1	
	Baltimo permit. Pag Department Important: injury or o		21. Signature of Funeral Service (Cense)  22. Name and Address of Facility  22. Name and Address of Facility	TO HREV	Mams PA	
	Physician		23a. Part. Into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	r respiratory arre	est, shock, or heart	Approximate Interval
	/Medical		falure. List only one cause on each line.  Immediate Cause (Final disease a. Gunshot wounds of head and back			Between Onset and Death
	Examiner		or condition resulting in death)  Due to (or as a consequence of):			
		<u>-</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_		
		Examine	cause. Enter Underlying Cause (Disease or injury that injuried	_		
	xecuted and transit	Exa	events resulting in death) Last  Due to (or as a consequence of):			
	O, be executed sician and burial - transi	dical	UNPENDED AMENDED	-		
			IF FEMALE: 23c. If yes, outcome of pregnancy	<del></del> .	23d. Date of delivery	
	Box 68760 e death certificate the attending phy ed for use as the t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna	ncy	Month [	Day Year
	Box 6 e death cert the attendir	ysic	1 Yes 2 No 9 Unknown 9 Unknown			
	P.O. I that the ned by t	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
	Division of Vital Records, P.O. Ita or Attending Physician: The law requires that the raster death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed b		1 Yes	2 No 3 Prot	topsy findings available
	ords aw requirents been 2 should	Completed		autops perfor	sy prior to d	completion of cause of
	Vital Reco ysician: The lav his certificate ha director, page 2	Som		1 ✓ Yes		es 2 No
	ician: ician: s certif rector	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 🗸 Other	" Scene
	of Viting Physical After this uneral direction	٠ <u>.</u>	1 ✓ Yes 2 No 1 Input 2 285. Time of Injury 28c. Injury at Work?	28d. Describe h	low injury occurred	
	on on ending ath.	tion	Natural 5 Pending May 8, 2010 0000 113 1 Yes 2 ✓ No	Subject shot		
	VISI or Att fter de Direct in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Ru	ral Route Number, City
	Spital sours a neral	Seri	7 Porticide	900 Block Nor	th Hill Road, Baltimo	
	Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
	To tl withi To tl	Med	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	
			O.C.M.E.		May 9, 2010	
	0./		30. Name and address of person who completed cause of death (Item 23a)			
	JV		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
		ate	31. Date filed (Month, Day, Year)  32. Refistrar's Signature			

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			Plea	se Type or Prin			delible Ink. artment of H					_	le.	
			1 - State Registrar				rtificate of I			-	Reg. N	0 0	10	5206
	Physici /Medic		1. Decedent's Name (First, Middle Walter A. Sko	rko, Jr.						2. Date of De Month May	13	ay 2	ŏ1o	3. Time of Death 10:30 <sup>a</sup> M
1	Examin		4a. Facility Name (If not institution 1317 Herkimer	Street				altimo	ore				of Death	
Ì	Funeral Director		5. Social Security Number  216-54-0344  Usual Residence of Decedent	6. Sex 7. Ag 1	e (In yrs. last birtl	hday) 'rs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 01/17/	th 9y, Year 195	o l	Coun.	ace (State or Foreign try) imore, MD
	yland how		10a. State 10b. County		10c. City, Town	or Lo							10	d. Inside City Limits
	Ba-f si	ctor	MD I	N/A			Baltin	nore						1 Kes 2 No
	with th	<b>Funeral Director</b>	10e. Street and Number				10f. Zip Code					itizen of Wh		•
	leath In 23	era	1317 Herkimer	12. Was Decedent	ever in U.S.	13 \	Was Decedent of H	21223		acify Yes or No		Unite		
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or items 23a or 28a-f show event, if a Medical Eventinar must be redified at	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ <b>X</b> ivorced	Armed Forces?			Was Decedent of H fYes, specify Cuba I □Yes 2X No	Specify:	Puerto	Rican, etc.)			, White, e	tc.
15-	"natu	lete	15. Deceden (Specify only highe	t's Education st grade completed)	16a. I	(Give	dent's Usual Occupa kind of work done of	during most	of worki	ng		Kind of Bus		•
212	should be filed withlir nd Mental Hygiene. marked other than matic event, II o IV	Completed	Elementary/Secondary (0-12)	College (1-4or 5			oo NOT use retired ections (	,	e <b>r</b>		l .			Maryland crections
	ould be filed v Mental Hygic larked other i	Be C	17. Father's Name (First, Middle,	,						(First, Middle,				receions
yla	should b and Ment s markec umatic e	To	Walter A. Sko					Er	ma I	Higgs				
Maryland	S all	H	19a. Informant's Name/Relations Bridget M. Sho		1 11		g Address (Street a							,
<u>6</u>	ges 1 and 2 t of Health If item 27 or other tr		20a. Method of Disposition				Larchmont sition (Name of natory or other place			ate		Location - C	_ <del></del>	
<u>E</u>	Pages nent of ant: If its ary or o		1 ☐ Burial 2 🗗 Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State pecify)			natory or other place brematory		5/17	7/2010	Ba.	ltimo:	re, N	Maryland
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service	Ligensee /		22	. Name and Addres	s of Facility	Huk	bard F	une	ral H	ome,	Inc.
	Physician		23a. Parri . Enter the disease, or strock, or heart failure. List Imme late Cause (Final disease or condition	cor p cations that caused only one cause on each lin	e.	ot ente	4107 Willer the mode of dyln	g, such as c	venu cardiac c	ie, Bal or respiratory a	timo rrest,	ore, 1		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due tour as	a consequence of									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Du (or as a	a consequence of	):							У	ears
,09	D = 100 P	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of	):								
289	certificate nding physise as the l	Medic		d					-					
ă.	the death ce y the attendii	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal death		Ectopic pregnancy Other (specify)	'				23d. Date Mont		y Day Year
rds, P	res the signer per display	ģ	Part II. Other significant condition	ons contributing to death bu	it not resulting in t	he un	derlying cause give	en in Part I.			obacco Yes 2			e cause of death?
Hec	I he law re ate has be bage 2 sho	Completed								24a. Was autop perfo 1 □ Yes		pri de	ere autop for to com ath?	sy findings available pletion of cause of
VITAI	cran: Sertific ector,	Be	25. Was case referred to medical examiner?				1-		of Death	(Check only o				
5	rthis ral dir	<u>ا ت</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp		t 3 □ DOA Othe	4 LI Nurs		ne 5 Nesid				)
VISION	naing ath. r: Afte e fune	atio	1 Natural 5 Pending 2 Accident investig	g (Month, Day	(Year) Inji	ury	Work	? ′es 2∐No		8d. Describe h	iow iriju	ry occurred	,	
DIVIS	or be rospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Certification:	3 Suicide 6 Could r 4 Homicide determ		ry - At home, farm . (Specify)	n, stre	et, factory, office		2	8f. Location (S City or Tow	Street a vn, Stat	nd Number e)	or Rural	Route Number,
:	ine nospir in 24 hour the Funer ipletely fill	Medical	29a. Certifler 1 ☐ Certifyin  (Check only one)  1 ☐ Certifyin  2 ☐ Medical	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/	death or inv	occurred at the timestigation, in my op	ne, date and pinion, death	place, a	and due to the ed at the time,	cause(s date an	s) and man nd place, an	ner as standard	ated. the cause(s)
,	To 1	Σ	29b. Signature and title of certifier	PA		ns	29c. License	number			29d. Da	ate signed (	(Month, D	ay, Year)
		-	Jonata	v - 100	mon	7	V 10002	13811			5/	14/ á	1010	)
		+	rongthan P Fo	who completed cause of de	711 (1:em 23a) (T)	<sub>ype, F</sub> Ptf	rfield a	d at	, A	Alen	hi	rnie	MV	) a10121
	Stat Registra	•	31. Date filed (Month, Day, Year)	1 7 20 0 32. Regista	r's Signature	1.	rfield h	ا د می	<u>/                                    </u>	TIMI	VV	11110	14(1	10 00

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. ? . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Charles Saden Edward 2:00AM 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTIMORE ATONSVILLE Frederick VIIIA NUTSING AND REHAB If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10-13-1916 Country) Months Hours Min. 1**X X**M 2 □ F 93 118-05-6000 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Baltimore Baltimore 1 Yes 2 X No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21227 985 Circle Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 XX es 2 □ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2XXNo Specify: Specify: White If Yes, Give 942-1945 Year or Dates 942-1945 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Inspector 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) ൧ Margaret Williams John Saden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 985 Circle Dr., Baltimore, MD 21227 Jean Marie Saden / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 05/18/2010 Odenton, MD W. Arundel Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA Signature of Funeral Sendce Licenses M01452 4023 Annapolis Road, Halethorpe, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 40 th.~ Physician/ FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Denentin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day s been signed by the should be detached g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b lirector, page 2 sl autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) မ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this (leted filled in by the funeral dir

examiner?	Hospital: 1  Inpatient 2  ER/Outpatient 3	DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1 🗌 Yes 2 🗌 No	28d. Describe how injury occurred
3 Suicide 6 Could not I		ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	ysician: To the best of my knowledge, death occure niner: On the basis of examination and/or investigation rse Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner state
29b. Signature and the of certifier	0 (1)	29c. License number	29d. Date signed (Month, Day, Year)
1	( Vkaint	D34551	May 17 2010
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)		/
Edmund Tkaczuk, M	MD 405 Frederick Road St	ite 100 Caton	sville, MD 21228

State Registrar

Medical

31. Date filed (Month, Day, Year)

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08:18AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** albrow W If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 M 2 □ F Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 <del>ØYes</del> 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Bla 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life\_DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r tarous College (1-4 or 5+) Elementary/Seconday (9-12) Ruck Drive Sutomotro 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) 000 000 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25772 permt. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 390 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 20-10 andrme 4 Donation 5 Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility 21. Signary md.2122 Mace 0 Wa 23a. Part Finer the Alease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fit ure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death ron Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year ed by the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Munknown cate has been signated to page 2 should to 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate | funeral director, pag 2 **Z**No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 Aesidence 6 \( \text{Other} \) Other (Specify) 2 X No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera (Month, Day, Year) 1 Natural 5 🗌 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🏸 🗽 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nume Frantianer: To the best of my incented as oneth occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMORE BALTIMIRE MD 21223 31. Date filed (Month, Day, Year) 32. Region ran Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician lian 1.02. PM May 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 408-72-3923 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21207 U5A Funeral ad Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 4 NO 1 Tyes Specify þ 3 Widowed 4 Divorced Bla c "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO\_NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) amon 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 22-201C 170. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses FUNERAL SERVICES 22. Name and Address of Facility 738 MD 21133 Kandallstown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events and as the burial-trar resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 Y No 3 Probably 4 Unknown funeral director, page 2 should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate has performe 2 🗌 No Yes 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2**X** No Hospital: 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) Certification: To 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes filled in by the 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division of Vital Records, P.O. Box 68760,

State Registrar DHMH 17 Rev 1/2001

Medical

29a. Certifier

(check only one)

29b. Signature, and title of certifier

within 24 hours a

61663 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

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			State of Maryland / De	-	irtment of H		and M	lental Hy	gie Reg.	2		15300
	Di cicio		1. Decedent's Name (First, Middle, Last)					2. Date of De	_		. 0 1 0	3. Time of Death
	Physicia Medio		Aradine Elisabeth Tardy					May Month	14	Day •	20ÎÖ	3:15 A™
-	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I						ounty of Deat	
	Funeral		20 Botany Court  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	(21/)	North Po	If Under 2		8. Date of Bi	#b	Mo	ntgome	
	Director		006-12-4173 1 □ M 2 M F 87 Yrs		Months Days	Hours		October		1922	2 Mai	thplace (State or Foreign untry) <b>ne</b>
	d ow t		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or	_								
	arylan a-f sh fied a	Director									i	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	he Ma or 28; notii	Dir	Maryland Montgomery North P	οt	10f. Zip Code				10a	Citizer	of What Co	
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	items items items			13. W	/as Decedent of His Yes, specify Cuban	panic Orig	in? (Spec	cify Yes or No-	_	$\overline{}$	Race - Ame	rican Indian,
36	after ( I", or kamir	d b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give		☐ Yes 2 X No		i deito i	ilcari, etc.)		Sne	Black, White	
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			30. Name and address of person who completed cause of death (Item 23a) (Type	. D .		3293			May	7 14	, 201	U
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Baltimore.

Amend #1, per MD g904 6/16/10 TT Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marilyn Towson Physician 10:15 PM Tausoni ೦೨ 03 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CARE NORTHPOINT BACTIMORE BACTIMORE FUTURE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Aug II) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1936 212-36-8096 1 □ M 2 🗓 F 73 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ehow other traumatic event, the Mudical Exeminer must be notified at MD Baltimore 1 Yes 2X No Director 10e. Street and Numbe 10f. Zip Code 21224 10g. Citizen of What Country? 1046 Northpoint Road USA Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Complet (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 dental technician healthcare 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) Richard A. Rathke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If item 27 1s any Injury or other trat <u>once.</u> George Towson/son 3 Bayship Road; Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥ Other (Specify) in state 21. Signature of Funaral Service Lice Stare Anaromy Board; 655 W. Baltimore Street Director Baltimore, Maryland 21201

234. Part1. Inter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** I hd Stage Dement Jears /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☑ No 212 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 1 16 Hospital: Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed use of death (Item 23a) (Type, Print) 362 Uses Salazar 31. Date filed (Month, Day, Year) 32. Regintrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Julia Agnes McNeely Vance Physician/ May 9, 2010 8:25 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2 X F Months Days Hours Min. 100 Jul 22 ay, 1909 New Jersey Director 150-36-5393 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c, City. Town or Location 10d. Inside City Limits Director Maryland | Montgomery Potomac 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 7809 Gate Post Way 20854 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates. Specify: Completed 3 ☒ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Physician Medical marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit, Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es George McNeely Agnes Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite C. Goldman/Daughter 7809 Gate Post Way, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Cremacoriam, rium, Inc. May 16, 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/ ROCKVIIIe, Maryland 20850 Montgomery Avenue 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 10 M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or in. Due to for as a consequence of signed by the attending physician and dbe detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No
9 ☐ Unknown B 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 🔀 No Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Vital 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Division of 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ₃ □ within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) spelistathis 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 17

32. Registrar's Signature

Sandra Delistathis, 8600 Old Georgetown Road, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rteah Yenafan		Stat 1- For State Registrar	te of Maryland /		ent of F ate of D		nd Mental Hy		eg. No.	2010	530
Physici ledical Exam	an/	1. Decedent's Name (First, Middle, L Anteah Yenafant		Vonofar	·+ o			2. Date of Dea Month April 30, 2	th Day	Year	3. Time of Death 0531 hrs
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<i>'</i>		Holy Cross Hospital	Ca.: 17 Ac.:	e (In yrs. last bir		Silver Spri		R Date of Bir		ntgomery	tholace (State or Earnie
Funeral Director		1	Sex 7. Age	45	- "	Months Da		Dec 25	5, 19		thplace (State or Foreign untry) <del>UNK</del> <b>hiopia</b>
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vith the Maryland s 23a or 28a-f shov notified at once.	Dire	10e. Street and Number 8445 Colesvill				0f. Zip Code 20910			USA	n of What Cour	
Baltimore, MD 21215-0036 permit Pages I and 3 should be filed within 72 hours after death with the Maryland bepartment of Heath and Mental Hygiens in the Heath and Mental Hygiens in the Maryland important: If item 71 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Mantal Status CHR- 1 X Never Married 2 Marri	1 Yes 2	Ever in U.S. UNK No	If Yes,	specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto			Race - Ameri White, etc.	can Indian, Black,
urs afte tural", aminer	þ	3 Widowed 4 Divorce  15. Decedent's Education (Specify	lf Yes, Give Year or Dates: y only highest grade com	pleted) 16a.	Decedent's	Usual Occup	lo specify: ation (Give kind of w	ork don <del>eunk</del>		-	
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760 ficate b g physis s the bu	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnancy			Ectopic pregna		23d. D	ate of delivery	
OX 6876 eath certificat attending phy for use as the	sician/N	past 12 months?  1 Yes 2 No 9 Unkno	4 Pregnant at t	time of dooth		(Specify)		noy	"	7.IU. E	rour rour
O. Bo t the dea by the a	ا≨۔	Part II. Other significant condition	9Unknown	but not resultin	ng in the unde	erlying cause	given in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
P.C ires that signed to be deta	۵	Hypertensive a			-		_	1 Yes	2 N	io 3 Prob	ably 4 🗸 Unknown
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Divis pital or A ours after eral Direc	Certification:	3 Suicide 6 Could n 4 Homicide		ury - At home, f	arm, street, fa	actory, office	building, etc.	28f. Location (\$ or Town, \$		Number or Ru	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death. To the Funeral Directort. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (	29a. Certifier 1 Certifying Physical Cone) 2 Medical Examin	sician: To the best of my ner:On the basis of exam and manner stated.	/ knowledge, de nination and/or	ath occurred investigation,	at the time, o	date and place, and on, death occurred a	due to the caus t the time, date	e(s) and mand place,	nanner as state , and due to the	ed. e cause(s)
H 3 H 5	ž	29b. Signature and title of certifier					se number			e signed (Mor	nth, Day, Year)
		30. Name and address of person wh	thall, mi	2			.M.E.		May 1	, 2010	
;		Pamela E. Southall, MD			er 111 F	enn Stree	et, Baltimore, M	ID 21201			
	ate	31. Date filed (Month, Day, Year)	2010 32. Registrar	's Signature	Car	Les .					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>010</u> Physician/ 11:00 A M 10 May Gordon Wells Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 5640 Morning Glory Trail New Market If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Country)
Bahamas 1 X M 2 □ F Months Min. (Month, Day, March 01 Yrs. 932 Director 212-92-6196 78 Usual Residence of Decedent shov 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c, City, Town or Location : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State Directo 1 Yes 2 X No Frederick Maryland New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21774 United States of America 5640 Morning Glory Trail Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Wells Hilda Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5640 Morning Glory Trail, New Market, MD. 21774 Georgia Wells (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/2010 Glen Burnie, MD Atlantic Crematory 21, Signat of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge Memorial Park, 7250 Washington Blvd. Part 1. Enter the disease, or complications that shock, or leart failure. List only one cause on Elkrid e Apple Mariate 21075 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final ANCER Sophagen Ph\_sician/ Yenn disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Yes signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 2 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA မြ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 🕅 Natural 5 Pending Accident Investigation by the f s after death Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Directory

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

KRMR

32. Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO

180

1.05

29c. License number

D0035152

29d. Date signed (Month, Day, Year)

Johnson Dave Frederick, MO 21702

			Plea	se Type or P						•		•	
			For State	State of	Maryla		epartment <i>Certificate</i>			lental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle	ie. Last)			Certinicate	OI Dea	111	2. Date of De	Reg. No.	2011	3. Time of Death
	Physicia		Lucille	В.	1	West				Month May 14,	. 201		5:30 A. M
1	/Medic Examin		4a. Facility Name (If not institution	n, give street and numb	per)		4b. City, To	own, or Locati		7		County of Deat	
			Rock Spring Vi		Ago (In s	rs. last birti	For	est Hi	<b>1</b> đểr 24 Hrs. J	8. Date of Bir	H	arford	hplace (State or Foreign
	Funeral Director		216–16–0732	1 M 2 M	. Age (111 y			Days Hou	rs Min.	(Month, Da	ay, Year) 19	23 Mary	rland
	D		Usual Residence of Decedent			Oit Town				July 5.	, ,,	25 [ 1411 ]	10d. Inside City Limits
	f shov	ō	10a. State 10b. County  Maryland Harf	ford			or Location						1 □Yes XXNo
	r 28a-	Director	10e. Street and Number	LOIG	В	el Ai	10f. Zip (	Code			10g. Citi	zen of What Co	untry?
	th with		414 E. Ring E	Factory Roa	ad		210	040			Unit	ed Stat	es
	tems	Funeral	11. Marital Status	12. Was Deced	es?	U.S.	13. Was Decede If Yes, specif	nt of Hispanic y Cuban, Mex	Origin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White	
33	hours after death with the Maryland tural", or Items 23a or 28a-f show at Evanity report to notition	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 21	No Spec	cify:			Specify: Whi	te
2-003b	in 72 hours after death with the Marylan "natural", or items 23a or 28a-f show	eted	15. Decedent	nt's Education		16a.	Decedent's Usual	Occupation	most of working	na	16b. Ki	nd of Business/	Industry
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		(Give kind of work life. DO NOT use				T . J .	-1 7	
Z D	be filled withi ttal Hygiene. d other thar event, Its M		17. Father's Name (First, Middle,	Last)		UI	fice Mana		other's Name	(First, Middle			Instruments
land	Mental Mental arked o atic eve	To Be	Frederick Bed	ckman				Ber	ryl Leo	onard			
Mar	2 should be and Menta Is marked raumatic ev		19a. Informant's Name/Relations! Michael West /				Mailing Address (						
e) e	1 and Health em 27		20a. Method of Disposition	5011	201		4 E. Ring		~	Bel A		mary Lan	
altimor	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic evonce.		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 ☐ Removal from St	ate i		Disposition (Name of crematory or oth od Cemete		May 1				
<u>=</u>	permit. P Departm Importar any injur		21. Signature of Funeral Service.								Park Pmati	on Serv	Maryland rice-BelAir
מ	89 <b>= 8</b> 8	_	/anda	bouge			3 Newpo	rt Driv	ve Fore	est Hil	1, M	aryland	1 21050
			23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	// - :		eath. Don		of dying, such	n as cardiac c	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. tailu		sequence o	1 hvive						
."	Examiner		Convention list conditions		ntia		•						
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a cons	equence o	f):						
	executed n and al-transit	Examiner	that initiated events resulting in death) Last	c	r as a cons	sequence o	f):						
2	be icia	_		d									
200	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the I	Physician/Medica	IF FEMALE:	÷332									
ROX	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	th 2 🗆 F	etal death	3 ☐ Ectopic pre					23d. Date of de Month	livery Day Year
j.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknov		or death	5 □ Other (spe	City)					
χ, Τ.	w requires that the d been signed by the should be detached		Part II. Other significant condition	-		-							the cause of death?
Ď O	require een si rould b	ted 1	Hypertension,	, Depress	ion,	21	emporal	arte	eritis	1 🗆	Yes 2	No 3□P	robably 4 🗌 Unknown
မ္	has b	Completed by			-					24a. Was		24b. Were at prior to death?	utopsy findings available completion of cause of
Vital Records	an: Th lifficate or, pag		25. Was case referred to medical	1				26 P	lace of Death	1 □ Yes	2 No		2 □ No
<b>-</b>	nysicia nis cer direct	lo Be	examiner? 1 Ves 2 Mo	Hospital:	patient 2	ER/Out	patient 3 DOA					6 ☑ Other (Spe	ocity) Assistant Living
0 0	ing Pt	:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	19	Injury Day, Year	28b. T		c. Injury at Work?		28d. Describe	how injur	y occurred	
VISION	Vitend death ctor: ,	ficat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be	f Iniury - A	t home, far	m, street, factory,	1 ☐ Yes 2		28f. Location	Street an	d Number or R	ural Route Number,
2	al or / s after al Dire	Certification: To	4 ☐ Homicide determ	building	g, etc. <i>(Sp</i>	ecify)				City or To	wn, State	)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical		ng Physician: To the b Examiner: On the bas and manne	sis of exam								
	To the	Me	29b. Signature and title of certifier	" Aly	1/4	-/		License numb				te signed (Mont	
	ا , ا		•	// ()	J	~   .		0059	281		05	114/2	010
	61		30. Name and address of person DV. All Naguik	who completed cause $\partial_{\alpha} M D = \partial_{\alpha} C$	of death (	item 23a) (	Type, Print)	st Hil	I, Mh	2105	Ó		
	Sta		31. Date filed (Month, Day, Year)	1. 7 9	gistrar's Si	gnature	6 1					<u>-</u>	
	Registra	ar	MAY	17 2010	Zenew	n p	1. gar						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5.9 per fb g903 5-17-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 11:21 May 2010 10 Joseph /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner Baltimore s. 8. Date of Birth (Month, Day, Year) 405 Dita timore inai If Under 1 Year | If Under 24 Hrs. Birthplace (State or Folia)

Country) 5. Social Security Number 003-09-4074 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1€M 2□ F 88 Yrs. June Director Usual Residence of Decedent 10d. Inside City Limits the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extending Item and the notified at once. 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No Director altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number alaa Completed by Funeral 2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 □ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14482 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 0 4 ☐ Donation 5 ☐ Other (Specify) 18434 21. Signature of Fundamental Service Licensee 22. Name and Address of Facility Jessup, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause Final disease or connition resulting in death)

a.

Due to (or as a second size of the control of the c Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner ute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en this certificate has al director, page 2 s autopsy 2 No 2 No 1 TYes 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 24 hours after death.

E Funeral Director: After thi letely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Matural 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ပ္ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital M.1). gletrar's Signature 31. Date filed (Month, Day, Year)\_ State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Mayonth 16, Edward Zulauf, III 2010 4:25 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min Months Mary land Director 56 213-68-7626 Usual Residence of Decedent 28a-f show 10a State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 ☐ Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Virginia Avenue 21221 U.S.A. items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by within 72 hours after Maryland 21215-0036 Yes 2 1 No Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 Widowed 4 K Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) it. Page 1 and 2 should be filed within thrent of Health and Mental Hygiene retant: If item 27 is marked other the njury or other traumatic event, the Sea Captain Military Sea Lift Cmd. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Zulauf, Jr. LouAnn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
717 Maryland Avenue, Baltimore, Maryland 21221 Lauren Zulauf (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, injury 4 Donation 5 Other (Specify) 05/19/2010 Baltimore, Maryland Bayview Crematory 21. Signature of Faneral Service Line insec 22. Name and Address of Jacobs P.A. Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Sher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician. IVES ho ea Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal deal ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 🗀 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Unan 0 اطا 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUSIS am, norma 6 Day, Year) 32. Paristrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No., ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2010 AELDIN HBDOUN /Medical ity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL 9. Birthplace (State or Foreign 8. Dale of Birth (Month, Day, Year) If Unde Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Davs Hours Min. 78019 Yrs. **Director** 24 1960 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantine must be positive at any injury or other traumatic event, the Modical Evantine must be positive at agine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1□Yes 2XNo þ If Yes, Give Year or Dates: Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Naumowicz 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial PK 15/2010 Baltimore, MD 22. Name and Address of Facility 4300 Wabash Ave. 21. Signature of Funeral Service License March F.H. West Janan Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ENTRICULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ACOUC Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient → ER/Outpatient 3 ☐ DOA 1 ☐ Yes completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural after death. death. 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and fitt of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 operson who completed cause of death (Item 23a) (Type, Print) 30. Name and ad BENJAMIN 31. Date filed (*Month, Day, Year*) **NAY 18 2010** State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month W. Alton James 05 2010 5:10a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 0.3 Months Days Hours Min. Year 86 Director 06 MD 3-22-0354 shov 10a. State 10b. County 10c. City, Town or Location with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Yes 2 No MD NA 10e. Street and Number 10g. Citizen of What Country? Funeral 1008 Lyndhurst U.S.A. Street permit, Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importants If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evaminar mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Maintenance na Public Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ <u>Dessa Hawkins</u> <u> Herman Alton</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 008 Lyndhurst Street, Baltimore, Md 21229 Yvonne Oliver-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 5/20/2010 4 Donation 5 Other (Specify) Loudon Park Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/h West
4300 Wabash Ave, Baltimore, non 21215 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a con uence of): Examiner Mars Sequentially list conditions, Examine cause (Disease or iinjury safter death.

Director: After this certificate has been signed by the attending physician and I not the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Dementio 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral to 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No **Hatural** 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. EUTAW ST SINTE 308

32. Registrar's Signature

BALTIMORE MD

29c. License number

D31464

2/201

29d. Date signed (Month, Day, Year)

CIM IMPRITY A SILACHZ

5/17/10

10-03744 Glen Atkins, Sr. 

		I- For State		,	Ċ	ertific	ate of D	Death		,	-	Reg. No	).			
Physician/ 1. Decedent's Name (First, Middle, Last)										2	. Date of De Month	ath Day	Yea	ır	3. Time of	
Medical Exami		Glenn		Ear	cle			kins			May 15,	2010			1533	nrs
		4a. Facility Name (			umber)			City, Town, o Baltimore	r Location o	of Death		4	c. County o	of Death		
				# 913 6. Sex	7. Age (In yr	s last hid		If Under 1 Ye	ar Iftinde	er 24Hrs.	8. Date of B	Righ/MN	4/DD/YYYY	V 9 Riet	hnlace (Sta	te or
Funeral Director		5. Social Security I						Months Da		_		31	41	Foreig	n	MD
Birector	-	220-38-		1 M 2 F	68	3	Yrs.				10	21	41			ri D
any	ŀ	Usual Residence of 10a. State	10b. County		10c. C	ity, Town	or Location								10d. Inside	City Limits
<u> </u>	_	MD	NA			Bal	timo	ce							1 X Yes	2 No
Aaryland 28a-f show 1 at once.	윉	10e. Street and Nu		<del>-</del>				Of. Zip Code				10g. Ci	tizen of Wh	nat Coun	itry?	
ith the Maryland 23a or 28a-f sho notified at once	Director	1701 Eu	taw S	treet A	ot 913	3		2	1217				U.	S.A		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	<u>a</u>	11. Marital Status		12. Was De	cedent Ever in			ecedent of H specify Cuba				lo-	14. Race White		can Indian,	Black,
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215 be file oral Hy rked o	Be	James A	tkins						Dore	othy	Lee					
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Vital Records, P.O. hysician: The law requires that th this certificate has been signed by I director, page 2 should be detach	d b										1 🗌 Y	es 2[	<b>√</b> No 3	Prob	ably 4	Unknown
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Division of Vital Records, tall or Attending Physician: The law requir safter death.  al Director: After this certificate has been so led in by the funeral director, page 2 should in the funeral director, page 2 should.	Completed										per	formed?	?   0	death?		
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Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	4 Homicide		mined (Specify						0.00						
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death.  When the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it		29a. Certifier 1 (Check only one) 2		nysician: To the be miner:On the basis												
To the within To the comple	Medical	29b. Signature and		and manner					nse number				l. Date sign			ar)
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$\phi$		Margarita k		Assistant Me			111 Per	n Street, I	Baltimore	e, MD 2	1201					
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Regis		MAY]	. 8 2010	[ Brasce	J. J.	Jan a	Kal									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY LEA ABELL, SSND May 14 2010 9:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MARIA HEALTH CARE CENTER Baltimore County Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛱 F Months Days Hours Min Jan 12 187-44-8581 **Director** 86 1924 Washington DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland 1 Yes 2 No Baltimore County Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral death with 6401 North Charles Street 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Religious Nun</u> Christian Ministry other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert C. Abell Catherine B. Brahm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Bernice Feilinger, SSND 6401 North Charles St., Baltimore, Maryland 21212 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 🏂 urial 2 🗌 Cremation 3 🔲 Removal from State Villa Maria Cemetery 5/18/2010 Donation 5 C Other (Specify) Glen Arm, Maryland ure of Funeral MITCHELL WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryland Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 0 neurs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events month burial-transit The law requires that the death certificate be executed entive Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Yes 2 No for in the past 12 Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Coronari certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medic Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this or
illed in by the funeral dire 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature tle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 05-1 (0 wi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jia Gu, 7505 Osler Drive, #312, Towson, Maryland 21204 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Flav 7/9009

			For State Registrar	otato of mary	Cer	tificate of			Reg. No.		
	Physicia Medic		1. Decedent's Name (First, Middle, Las	Boy Kin	5			2. Date of De Month		Year /	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give Loch Raven	street and number)		000	r Location of Death		4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. St 218-60-3656	7. Age (In	yrs. last birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da NOV 1		g. Birth	place (State or Foreign try) vland
	/land f show ed at	tor	Usual Residence of Decedent  10a. State  10b. County	ľ	c. City, Town or Lo						0d. Inside City Limits
	he Man or 28a- or otifie	Director	MD N/2	A		Baltimo	re		10g. Citizen o	f What Coul	1 X Yes 2 □ No
	h with t ns 23a must be	Funeral	5501 Mayview A			2	1206			USA	
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces?  1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba I □ Yes 2XXNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- o Rican, etc.)		ace - Americ ack, White, fy: Bla	etc.
Baltimore, Maryland 21215-0036	within 72 hor giene. ier than "nat is, the Medica	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12) 12th Grade		(Give i	dent's Usual Occup kind of work done O NOT use retired) Clerk	during most of wor	king		al Se	<sub>dustry</sub> curity ation
/land	d be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) James Boykin,	Sr.			18. Mother's Nar Gladys		Maiden Surnar	ne)	
, Mar	nd 2 should be saith and Menta n 27 is marked er traumatic e		19a. Informant's Name/Relationship (7) Cheryl Thomas,				and Number or Ru W Avenu				
timore	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	)	0b. Place of Dispo cemetery, cren Garriso	n Fores	t Vet.	Cem.		s Mi	lls,MD
Ball	permit Depari Impor any in		21. Signature of Funeral Service Licens	Harris	4	Name and Addre	<sup>ss of Facility</sup> Ch air Roa	atman- d Balt	Harris imore,	Fun MD	eral Home 21206
	Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	cellula	**		or respiratory an	rest,		Approximate Interval Between Onset and Death MI KNOW IN
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a cor	nsequence of):					73	
8760	ificate be executed g physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a cor	nsequence of):	-					
. Box 687		_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No g Unknown	23c. If yes, outcome of pr 1  Live Birth 2 4  Pregnant at tim 9  Unknown	Fetal death 3	Ectopic pregnand Other (specify)	су			ate of deliver	ery Day Year
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Division of Vital Records,	: The law req cate has bee , page 2 sho	Completed								. Were autopyrior to codeath?	osy findings available mpletion of cause of
Vital	Physician: 1 r this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	2 ER/Outpatien	Oth	er:	ome 5 Resid	dence 6 0 Ot	har (Spacifi	
on of	anding Phy lath. rr. After thi ne funeral		27. Manner of Death  1 Vatural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injur work	y at	28d. Describe h			·
Divisi	tal or Atter rs after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		eet, factory, office		28f. Location (S City or Tow		per or Rural	Route Number,
	the Hospi iin 24 hou the Funer ipleted fil	Medical	(Check 2 Medical Examination only one) 3 Certifying Nurs	ician: To the best of my k ner: On the basis of examine Practioner: To the best	nation and/or invest	igation, in my opinio	on, death occurred a	it the time, date a	nd place, and d	ue to the car	use(s) and manner stated.
	vith con		29b. Signature and title of certifier	Colo	DMI	29c. Licenso	359(o	it10)	29d. Date sign	ed (Month, l	Day, Year)
	21		30. Name and address of person who c	ompleted cause of death	MIT (Item 23a) (Type, P Raven B	rint)	1 Rales	In.	3 //	70	- 70
ı	Stat Registra	.6	31. Date filed (Month, Day, Year)		ignature	OUPEVATE	( IJU/), In	ere, Ina	Mand	21	10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Ye ar Month **Physician** 8:04PM Ma Robert Lee Burton 2 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St-Agnes Huspital

5. Social Security Number 6. Sex Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 □ F 85 Virginia Director 231-16-9373 Jan.10,1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1. Yes 2 No Director Maryland N/ABaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 626 N. Hilton Street 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 💥 ☐ No Specify: Completed by 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Eastern Stainless 10th grade <u>Steelworker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harrison Burton Louise ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 229 19a. Informant's Name/Relationship (Type. Print) 626 N. Hilton Street Baltimore, Maryland Virgil Powell/ Companion 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park Arbutus, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Surviva License 5240 Reisterstown Rd Baltimore, MD 21215 1 arris Approximate Interval Between Onset and Death 23a. Par v. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart allure. List only one cause on each line. Immediate Cause (Final Acute myo cardial Interetion **Physician** MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hronic Obstructure Pulmonary Ycars if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed Diabetes Mellitus burial-trai resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No atter 3 Ectopic pregnancy Year for Month 5 ☐ Other (specify) ned by the a Ö 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 No 1 ✓ Yes 2 ☐ No 1 ☐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To ð 28c. Injury at Work? 27. Manner of Death 28a, Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: /
filled in by the fi 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D416505 MD 12.2010 Manmol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes Hospital, Baltimere, Maryland Twanmoh MD JUSEPH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Denve S.

DHMH 17 Rev 1/2001

Registrar

				Please	Type or Pri AMEND 17 State of M	int in B	lack In	delibler FH	e Ink G903	ealth	ure A	II Copie	s Are	Leg	ible.		
	For State Registrar					Certificate of Death						Reg. No.					
Physician/			1. Decedent's Name (First, Middle, Last)										Date of Death     Month Day Ye.			3. Time of Death	
	Medica	al -	17 ELE		A ILE Y estreet and number)	•		4b. City.	own, or	Location of	of Death	05	-	2 2 . County	0.10 of Death	19:15 P.™·	
Examiner			Good St	spit	uL	1.	3al	time		<u></u> ر							
	uneral irector	4	5. Social Security Number  216 - 84 - 9008  1 M 2 F  7. Ac  1 Usual Residence of Decedent				e (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs. 8. Date of Birthday)  Yrs. Months Days Hours Min. (Month, Days)							Year) 9. Birthplace (State of Country) MARYLA			
ıryland	a-f show iled at	- h	Usual Residence of	10b. County			10c. City, Town or Location Ballimore							10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
ith the Ma	23a or 28a st be notif	ral Dire	10e. Street and Number 533 Oakland Ave.				10f, Zip Cod 21212						10g. C	itizen of V	Vhat Cour	ntry?	
2092 , <b>21215-0036</b> within 72 hours after death with the Maryland ordene.	o in	امِ ا	11. Marital Status  1 Never Marri 3 Widowed	ied 2  Married	12. Was Decedent Armed Forces? 1 Yes 2 V If Yes, Give Year or Dates.			Vas Decede Yes, speci				cify Yes or No Rican, etc.)	)-		k, White,	van Indian, etc.	
215-0036 in 72 hours after	han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. Kind of Business Security			dustry	
y 992 0. yland 212 yland 212 Mental Hydiene.	other t	ωŀ	17. Father's Name (			5 var		18. Moth	er's Name	(First, Middle	First, Middle, Maiden Surname)						
aryland	rked c	卢	ALgie	Ba	iley					12.	olo	2	House				
e, Maryland and 2 should be filed Health and Mental Hy	tem 27 is ma		19a. Informant's Name/Relationship (Type, PrInt) D S. Ster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RESETTA DOLMES I SUCIEY COURT Randal Hown Ned.														
Baltimore,	ortant: If item injury or othe		20a. Method of Disposition  1 Durial 2 Cremation 3 Removal from State  4 Dongton 5 Other (Specifi)  20b. Place of Disposition (Name of cemetery, crematory of other place)  Wood (awn Cemetery 5 17 10 Builto Nd.										own, State				
Balti Permit.	permit. Page 1 Department of I Important: If it any injury or o once.		21. Signature of Fu	eral Service Licer	mollin		22	. Name and	Addre	of Facilit	My	1/2 Kg	nef	ype	No.	21213	
			23a Part 1. Enter t shock, or hear Immediate Cause (	rt failure/List only	nplications that cause one cause on each lin	ed the death.	. Do not ente	r the mode	of dying	g, such as	cardiac o	r respiratory a	arrest,	70.	nec-	Approximate Interval Between Onset and Death	
М	sician/ ledical aminer		a. Unit to consecution resulting in death)  a. Unit to consecution resulting in death)  Due to (or as a basequence of):														
\	sit	Examiner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	onditions, nmediate orlying	a conseque	consequence of):											
e executed			that initiated events resulting in death)	S	c. Due to (or as	r() ( V V ) s to conseque	P.C. D./( ence of):	4000	<u>r.                                    </u>								
<b>760</b>	physics the b	edic		•	d												
P.O. Box 68760 that the death certificate b	the attending physicia shed for use as the bur	Physician/Medical	FFEMALE:   23b. Was decedent pregnant									ery Day Year					
Lipper Gasteointenstinal bleeding Accite Renaffail e, 1 = yes 2 = No  Cauda Equina Syndrome, Severe Malnutrition, 24a. Was an autopsy performed?  1 = yes 2 = No								tribute to the cause of death?									
								Yes 2	es 2 No 3 Probably 4 Unknown								
of Vi	r this c	e: 10	1 ☐ Yes 2¥ 27. Manner of Deat	√No h	28a. Date of inj	ury 28b. Time of 28c. Injury at 28d. Describe how in											
on C	or: Afte	ficat	Natural 2 Accident	5 Pending Investigation		ay, Year)	injury	М	work 1 🗌	? Yes 2 🗆	] No						
Divisi lal or Atte	To the Funeral Director: After this certific completed filled in by the funeral director,	Il Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could not determined	uld not be					factory, office 28f. Location (Str. City or Town,					eet and Number or Rural Route Number, State)		
e Hospil	e Funera	Medical	(Check 2	Medical Exar	ysician: To the best on niner: On the basis of arse Practioner: To the	examination	and/or invest	tigation, in r	ny opinio	n, death o	ccurred at	the time, date	and plac	e, and du	e to th <b>e</b> ca	use(s) and manner stated	
To the	To th	~	29b. Signature and		)			29c		number			204 D		d (Month	Day Yearl	
	n		30. Name and addr	ress of person who	completed cause of	death (Item	23a) (Type, F		Loc	6 Ro	iven A	alud		1	/		
	7		SANTOS4	DATTAL	- Good Jam	oritan	HOSP	tol,	3	altin	nore.	MD-	2123	9.			
	Stat Registra		31. Date fled (Mont	18 2010	Acres 32. Regist	rar's Signati	back	9			,						

15315

		-	For State Registrar	State of Maryla	•	tificate of E		мена пу	Reg. No.				
	Physician/		1. Decedent's Name (First, Middle, La			_	2. Date of De Month	ath Day	Year	3. Time of Death			
****	Medic Examin	al	Dolores J  4a. Facility Name (if not institution, give	essica Brock ve street and number)		4b. City, Town, or	Location of Deat	th Value	4c. C	4c. County of Death			
	LXanini	CI	Balt. Wash. Medi	cal Center		Glen B			'	Anne Ar	undel		
	Funeral Director		5. Social Security Number 6. 212-28-2501	Sex 7. Age (In yn 1 ☐ M 2 Å F 7.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ıy, Year)	Coun	olace (State or Foreign try) rvland		
	T OW		Usual Residence of Decedent	Lan	City, Town or Loc	-41		12291					
	aryland a-f sho fied at	Funeral Director	10a. State 10b. County  Md. Anne Ar		cation				1	10d. Inside City Limits 1 ☐ Yes 2 ☐XNo			
	the M	٥	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?		
	h with	nera	1148 Thompson	Ave.	<b>-</b>		1144			USA			
8 ROCK 21215-0036	i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 ☐ No If Yes, Give 1			pecify Yes or No- to Rican, etc.)		Race - Americ Black, White, pecify: Whi	etc.		
80 5-0	2 hou "natu edical	plet	15. Decedent's (Specify only highest of		(Give H	ent's Usual Occup	ation during most of wo	rking	16b. Kind	of Business Inc	dustry		
27.72	vithin 7 iene. r than the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	life DO NOT use retired)								
	be filed w ental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle, Last				Maiden Su	Maiden Surname)					
) RES Maryland	uld be fil I Mental narked natic ev	욘	Peter	Onhei				nerine		Miller			
Mai	2 should Ith and Me 27 is marl traumati		19a. Informant's Name/Relationship Micheal Brock (	(Type, Print) Son)		g Address (Street a Thompson				City or Town, State, Zip Code)			
010 ore, N	of Health of Health if item 27 r other tr		20a. Method of Disposition	201	o. Place of Dispos	sition (Name of	<u> </u>	Date		ation - City or To	own, State		
$D\mathit{bL}_{H}$ Baltimore,	Page ment o tant: If jury or		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Metro Crematory Inc. 5/12/10  Baltimore.										
Ball	permit. Page 1 and 2 st Department of Health a Important. If item 27 is any injury or other tra once.	d	21. Signature of Funeral Servi & Libensge 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122										
d	Priysician Medical Examiner	2 %	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as A consequence of):										
		e.	Sequentially list conditions,	b. Due to for as a cons	mem	MT					Syean!		
7.	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.										
P	cate be executed physician and the burial-transit	al Ex	resulting in death) Last  Due to (or as a consequence of):										
760	icate be of physicials the bur	/ledical		d									
	th certif	Completed by Physician/N	F FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Ves   2   No   9   Unknown   Unknown   23c. If yes, outcome of pregnancy   23d. Date of deliving the pregnant at time of death   5   Other (specify)   Month   Month   Month   1   Month								ery Day Year		
ds, P.O	v requires that the dea been signed by the a should be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of the cause of the cause of death of the cause of death of the cause of the ca										
Recor	i: The law re icate has be r, page 2 sh							1 🗆 Yes	psy ormed?	24b. Were autop prior to condeath? 1 Yes	psy findings available mpletion of cause of		
/ital	sician certif lirecto	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	☐ EP/Outpation	Oth	ace of Death (Che		domas C	1 Other (Caselfe	A		
on of \	ktending Physician: The la death. ctor: After this certificate he y the funeral director, page	Certificate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati	28a. Date of injury (Month, Day, Year)	atient 2 ☐ ER/Outpatient 3 ☐ DOA						,		
Divisio	tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	t home, farm, stre	et, factory, office		treet and Number or Rural Route Number, n, State)						
_	To the Hospital or Attend within 24 hours after deat! To the Funeral Director: completed filled in by the	Medical	(Check 2 Medical Example only one) 3 Certifying Nu	nysician: To the best of my knominer: On the basis of examinations of examinations of the best of the	ation and/or invest	gation, in my opinio	on, death occurred e time, date and p	at the time, date a	and place, ar ne cause(s) a	nd due to the caund manner as st	use(s) and manner stated. ated.		
	To with		29b. Signature and liftle of certifier	m		29c. License	3977		29d. Date :	signed (Month, I	2010		
	2		30 Name and address of person who	completed cause of death (II	tem 23a) (Type, P	ORIVE,	Clen &	mue.	m	0. 2/	061		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	- AB B	P. (						

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, of Vital Records. Division

Baltimore, Maryland 21215-0036

certificate After this death. s after death within 24 hours a

State

(Check only one)

Eric

30. Name and address of person

Registrar DHMH 17 Rev 1/2001 South

29d. Date signed (Month, Day, Year)

Hanover Street, Baltimore City, Maryland 21225

and manner stated

no completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 2:20 PM Joe Clyde Baxley Jr. May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Dove House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Feb 18, Year 926 Months Days Hours Florida 1 🕅 M 2 □ F 265-24-9477 84 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XNo Maryland Sykesville Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21784 787 Gaither Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 107. 11. Marital Status Yes 2 No 1944 Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 1945 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) High School English Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of မ Ruth Evans Joe Clyde Baxley, Sr. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 787 Gaither Road Sykesville, Maryland 21784 f Health item 27 Donna H. Baxley, Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important; If ite
any injury or ot 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Page 1 Metro Crematory Inc. 05/17/10 Baltimore, Maryland 22. Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PAILURE Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Day Month Year detached 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Hospital or Attending Physician: The law performed? Yes 2 No death? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? **Division of Vital** Be Other: 2 No 4 □ Nursing Home 5 □ Residence 6 🕅 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending death. Investigation
6 Could not be Accident within 24 hours after deatl

To the Funeral Director:
completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying NurserPractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature mpleted cause of death (Item 23a) (Type, Print) NETHINSTER MD21151

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May  $13^{ay}$ Orrine , 20<sup>Ta</sup>o 5:21 ΑM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 929 Quantril Way Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours June 24, 217-40-6395 Maryland Director 66 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ha movified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 929 Quantril Way 21205 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)  $11\,\mathrm{th}$ College (1-4 or 5+) Cleaning Lady Cleaning Business Be 17. Father's Name (First, Middle, Last) (UNK) 18. Mother's Name (First, Middle, Maiden Surname) (UNK) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony & Glenda Bailey (son) Quantril Way Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of May Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Bohemian National 19, 2010Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee <u>Dundalk</u> Avenue Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Squamo os Cell Cancer Physician/ S/741 c Medical resulting in death) to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of, attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ englyseine 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv perfor death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 A Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 
Nursing Home Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work 2 Accident 1 🗌 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and til 29d. Date signed (Month, Day, Year) 40609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

State Registrar

Eager Street Baltimore, Maryland

1000 East

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of N	/laryla	nd / Depa	artment	of H	ealth a	and N	/lental Hy	/gier	1e	LA	15210	
1. [			1. Decedent's Nam	e (First, Middle, La	st)	Certificate of Death					2 Data of D	. No U   U		1001.			
and a	Physic Med				Shirley		M. Burkh		e		2. Date of Death Month		Day Year		3. Time of Death		
€	Exam	iner		street and number)			4b. City, T	own, or L	ocation o	f Death	May		5 20 4c. County	of Death	6:30 P M		
H	Funera	1	5. Social Security N	race Roa						gemer						ore Co.	
	Directo		218-26-		□ M 2 F		last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi	rth av. Year			place (State or Foreign	
	MO T	١.	Usual Residence of	Decedent		31						Dec. 2	19	28	Mar	yland	
	nylanı -f sh	155	10a. State	10b. County		10c. Ci	ty, Town or Loc	ation							1	0d. Inside City Limits	
	ne Ma or 28a notif		MD 10e. Street and Nun		imore							Edge	mer	e		1 ☐ Yes 2 ☐ No	
	with th	Funeral Director	3210 Gr	ace Road				10f. Zip C	ode				10g. (	Citizen of W	/hat Coun	try?	
	eath v	Į,	11. Marital Status	acc Road	12. Was Decedent	Ever in II.	S 12 W	/as Dagadar	4 25 1 12-	2121	9		U	nited	Stat	tes	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by I			Armed Forces?	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		I.S. 13. Was Decedent of F If Yes, specify Cubin 1  Yes 2 XNo			in? (Spec Puerto F	cify Yes or No- Rican, etc.)			- America c, White, e	tc.	
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Baltimore,	permit Depar Impor any in		21. Signature of Fund	eral Service Licens	"Ca	)	22	Vame and A	ddroce o	of English		ome of					
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7	Physician/ Medical		Immediate Cause (Fi disease or condition resulting in death)	inal	a <i>L</i>	Lung Cancer								10	Approximate nterval Between Onset and Death		
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Phys	rthis aral di	<u>e</u> [	1 Yes 2 7. Manner of Death	10	1 Inpatien		R/Outpatient 3	DOA C	Other: 4	☐ Nursing	g Home	5 Resider	nce 6	Other (S	pecify)		
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the h	thin 2 the mplet		orlly orle) 3 🗀	Certifying Nurse	Practioner: To the be	st of my kr	nowledge death	OCCUPRAD A	the time	4-4- (	od at the	une, date and	place, a	aria aue to t	ne cause(s	s) and manner stated.	
P	. S	2						29c. Licer	nse numl	ber		290	d. Date	Year)			
		Ronald	asio	29c. License number  P-28097  rted cause of death (Item 23a) (Type, Print)  O 9114 Philadelphia Rd. Srute  32. Registrar's Signature							5	117/10					
	OV		RONALD	ATTANAS	pleted cause of deat	h (Item 23) Phel	sa) (Type, Print)	hià R	21.	Suit	- 10	8 12.	11		4.	1 21222	
	State Registrar		. Date filed (Month, Da	ay, Year)	32. Registrar's	Signature		100		July	10	U PA	M	nose	, ma	. 4231	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Frederick Linwood Boone 2010 May 6:33 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, June 9 **Funeral** 9. Birthplace (State or Foreign Days 1 X M 2 - F Hours Min. Country) Director Vre 219-28-4370 June Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🗐 No Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Rd. 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 Divorced Specify: the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Plumbers & Pipe Fitters nd Mental Hygiene.
s marked other than "r
umatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) National Pension Fund Senior Programer Analyst Be . Page 1 and 2 should be filed or ment of Health and Mental Hyorant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Ernest Linwood Boone Alethea Rueckert or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Bockholt/daughter 1411 E. FM1717, Kingsville, TX 78363 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Valley Memorial Gardens Timonium, MD Dulaney Signature of Fundamental Signature of Sign 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Flagle 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and \_\_ath Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a onsequence of) Examiner Ray Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 2, 2010 P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 2 XN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ 1 ☐ Yes 2 🗷 No Other: 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending FREDERICK 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year) 314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

AAY 18 2010

Jenus 3. Registrar's Signature

A. Acade

ERNESTINE WRIGHT, M.D.

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year George K. Bostey 6',45 A M 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Seasons Hospice Randallstown 6. Sex 1 A M 2 A F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8–3–1923 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Mary Land Director 185-16-7401 Yrs 86 Usual Residence of Decedent 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
77 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9903 Southall Road 21133 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Supervisor M.T.A. 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dye Bertha permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Richard Bosley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Southall Road Randallstown, MD Joan Ann Muhl Bosley (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-15-2010 Sykesville, MD Lake View Mem. Pk. 22. Name and Address of Facility . Signature of Funeral Service Licenses ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, MD 21136 J. Wayne Osterling 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Gauco (Final Onset and Death Cancer Physician/ Luna disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 \(\text{No.}\) 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ns Rayapatre M.D 20x

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mith Av. S-235, Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31, per DVR g903 5/18/10 TT State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Clara Levada Beam 12 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba mane Wore rank If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 □ F Days Hours 184-22-8695 79 Director May 13, 1930 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show in than "natural", or items 23a or 28a-f shorthe Mayical Examiner must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No Director 10e Street and Number Rd 10f. Zip Code 10g. Citizen of What Country? 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XJYes 2 □ No 48-50 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married C/GH Bean Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manuary injury or other traumatic event, the Manuary injury or other traumatic event, the Manuary injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Medical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Louise Kohl Costa Ralph Walters ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara J. Franklin/Daughte 1224 Waugh Chapel Rd Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) May Date 17 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner aast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5/12/10 00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Baltimore, Md mo 9000 Heath Mance bo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10e, perFH, G904, 6/3/2010, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hobert 9 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Min. North, Day, Year Feb. 8, 1971 5. Social Security Number Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 39 Yrs 293-78-5405 Chio **Director** Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at ems 23a or 28a-f sh r must be notified a 1 Yes 2X No Director Prince Georges Maryland Laurel 10e. Street and Number 82006 Harvest Bend In. Apt 15 10f. Zip-Code 10g. Citizen of What Country? 20707 U.S.A. Funeral death items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status "natural", or iten edical Examiner r Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry marked other than "natu matic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M Telecomunications Engineer 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sharon Delores Mason Robert J. Braley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 West Knox Road, Beaverton, MI 48612 Mr. Robert J. Braley (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State New Hope Cemetery May 22, 2010 4 Donation 5 Other (Specify) Hope, Michigan permit. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkville
Evans Funeral Chapel & Cremation Services - Parkville 21. Signature of Funeral Service Licenses 8800 Harford Road, Parkville, Maryland 21234 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Grant middle Cerebral Drivery **Physician** disease or condition resulting in death) /Medical **Examiner** middle cerebral and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760, Physician/Medical attending a IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No Yes detached the Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has performed? 2 No 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ✓ No Hospital 3 🗆 DOA Other: 1 Inpatient 4 - Nursing Home 2 ER/Outpatient 5 Residence 6 Other (Specify) ၉ After this 27. Manper of Death Date of Injury Time of Injury at Work? 28d. Describe how injury occurred 28b. 28c. Certification: or Attending 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) Injury 2 🗌 No 1 ☐ Yes To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A death. 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 🗌 Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

^

31. Date Ned (Month, Day, Year)

32. Regiarar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OOO NOTHI WORK

600 North Wolfe St, Baltimore, MD, 21287

State Registrar park

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ hen ma-2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ede Itimore 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign Funeral Days 1 🕅 M 2 🗆 F Hours Min. (Month, Day, Year, 58 Director March 10, 1950 maShow 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumafte event, the Medical Examiner must be notified at traumatte event, the Medical Examiner. 10a. State 10b. County 10d. Inside City Limits Director 1 **☑** Yes 2 □ No MD altimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21210 sidgemede "K 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) SA Wrestlin Elementary/Seconday (0-12) College (1-4 or 5+) Photographen permit. Page 1 and 2 should be filec. Department of Health and Mental Hy, Important: If item 27 is marker any injury or other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ္ largaret rown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) altimore MD2121 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Euans, Funeral Chapel + Cremation Services 16924 York Road, Monkton MD 21111 Signature of Funeral Service Licensee 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition rala myoca Medical resulting in death) **Examiner** oronau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) the detached 9 Unknown 9 Unknown P.0. ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed k þ Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 🗌 No Yes 2 1 Yes Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 E 24 hours after death. Funeral Director: After this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical

within 2

29a. Certifier

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McConnell William D.

May 17,2010

6301 N. Charles St BALTO MB 21212

State

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D42129

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ May Day 6, 5:45 AM, 2010 John Fred Buchanan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday 8. Date of Birth Funeral Months Days Hours Min (Month, Day, Year) 1 M 2 🗆 F 53 Maryland 195 219-70-3204 Director Usual Residence of Decedent r 28a-f shov notified at 10b. County 10a, State 10c. City. Town or Location death with the Maryland 10d. Inside City Limits Director 1 Tes 2 No Parkville MD Baltimore 10f Zip Code 10e Street and Number 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 21234 United States 2828 Cub Hill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 2 No Yes Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: "natural". Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Food Service Be filed 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H

27 is marked of

traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ٥ McGraw Barbara William Buchanan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Buchanan /Wife 2828 Cub Hill Rd. Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 18 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 1900 disease or condition Medical resulting in death) Lue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No the be detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 🗌 Probably 4 🗀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tyes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury accurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

State Registrar

Medical

31. Date filed (Month) Day, Year)

60019

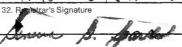
29a Certifier (Check

3 🗌

30. Name and address of person who completed cause of death (Kem 23a) (Type, Print)

NADW

29b. Signature and title of certifie



Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

16

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26 pe State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10,<sup>Day</sup> **Physician** 3 A Beulah Ola Bailey May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Owings Mills Baltimore 8912 Maple Brook If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country)
Sept.12,1915 Virginia 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🛛 F 94 215 22-9899 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner must be nuffled at M∑Yes 2 No MD Baltimore Owings Mills Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21117 USA 5003 Hollington Drive 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black 1 □ Yes 2 🔀 No Specify þ 3 Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 11th College (1-4or 5+) Public School Cafeteria Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Street Preston Winkler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ralto, Co, 21117 19a. Informant's Name/Relationship (Type. Print) 5003 Hollington Drive Balto, Co, Ruth Frazier (daughter) Department of Hear, Important: If Item 27.

any Injury or other once. Health tem 27 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lorraine Park Cem. May 25,2010 Balto.Co,MD 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Ature of Funeral Service Licensee 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZHEIMER'S **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760. death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) should be detached 9 Unknown The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown CARDIOVAICULAR 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an scertificate has be irector, page 2 st autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director. Be Friends Home Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation after death the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier W.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE 10 UMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Theresa E. Ciarpella 07:25 AM 2010 MA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT JUSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Months Davs Hours Min. (Month, Day, Year) ine 13, 1948 Maryland Director 220-50-2131 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director MD Harford Bel Air 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1018 Vale Road 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Floral Floral Arranger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Salvatore Ciarpella Elizabeth Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Ciarpella, brother 1018 Vale Road Bel Air, Maryland Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Department of Important: If any injury or Metro Crematory, Inc. 05/18/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. EMA 299 Frederick Road Baltimore. 23a. Part 1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC ₽nysician/ BREAST CANCER disease or condition resulting in death) 2 YEARS Medical Due to (or as a consequence of): Examine ATIC FAILURE Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury JEMOLYTIC ANEMIA WEEKS that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Pregnant at time of death Unknown 9 Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THROMBOTIC THROM BOCYTOPENIA Hospital or Attending Physician: The law requires 2 No 1 🗆 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform after death.

Director: After this certificate! 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Funeral Director: After thi completed filled in by the funeral 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 46082 Usu Dande 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Y 18 2010

31. Date filed (Month, Day, Ye

DESHPANDE, M.D. 7601 OSLER DRIVE

TOWSON MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2010 na /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimo: If Under 1 Year | If Under 24 Hrs. ] Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 😿 F Yrs 26, 1938 Maryland Dec. Director 213-36-6666 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: fi them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fire Mydical Exactions in interfere traumatic event, fire Mydical Exactions. 1 ☐ Yes 2 ☑ No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 21228 USA Funeral 3 Holmes Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: <u>م</u> 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Goldie Weisberg Herman Falk ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Holmes Avenue; Catonsville, MD 21228 Spence Coleman Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal from State Atlantic Crematory 5/18/2010 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, 1630 Edmondson Avenue; Caton Schock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 2 🗌 No 3 Probably 4 Unknown 1 ¥Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 27. Man er of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Tyes 2 🗆 No n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi 2 Accident Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month,-Day, Year) .

DHMH 17 Rev 1/2001

Hanover Sheet Balkmare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 8:35A Charles Cain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u> Gilchrist Hospice Center</u> Towson If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) MD 1 X M 2 □ F Days (Month, Day, Year) 03-19-49 Hours 218-48-3845 61 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No NA MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 452 Pitman Place 21202 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 11. Marital Status Armed Forces?

1 Yes 2 No Never Married 2 Married <u>≨</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Self-employed 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be Charles L. Cain Runette Convers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Pitman Place Baltimore <u> Sharon Riddick-Friend</u> 20a. Method of Disposition
1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 05-21-10|Lansdowne, MD 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 638 Gilmor Street Baltimore.MD Ν. 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final Physician/ ance 16955 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauce. E. a. Un Jarryn g Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 g Unknown 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed No 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? No 1 
Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be 3 Suicide within 24 hours after de

To the Funeral Directo

completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe HOMANS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Quan: 6701 MZOV 31. Date filed Mo ith, Day, Year) egistrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	aryiano		artment of F tificate of E		and Mental Hy	gien Reg. N	001	0 153	3 (
	Physicia	ın/	1. Decedent's Name (First, Middl Marlene	e, Last) Virgi	nia		Clay		2. Date of De Month	ath	Day Year 2010	3. Time of Death	
	Medid Examir		4a. Facility Name (if not institution	n, give street and number)			4b. City, Town, or	Location o	May of Death		c. County of Dea		М
	<i>t</i>		3433 Augusta					heste			Carrol1		
	Funeral Director		5. Social Security Number 213-34-3319 Usual Residence of Decedent	6. Sex 1  M 2  T F 7, Age		st birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Date of Bir Min. (Month, Da July 2	th y, Year 1	9. Bit	thplace (State or Fore puntry) MD	ign
	aryland a-f show fied at	Director	10a. State 10b. County	Arundel		Town or Local						10d. Inside City Limi	
	the M or 28	Dir	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Co		140
	th with ns 23a must b	Funeral	1207 Woodale				21122				S.A.		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorced	If You Give		lf	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🖾 No		jin? (Specify Yes or No- , Puerto Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	e, etc.	
15-(	72 hou n "natu Medica	nple	(Specify only high	nt's Education est grade completed)		(Give k	ent's Usual Occupa		of working	16b.	Kind of Business	Industry	
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Maryland 21215-0036	d be filed fental Hy irked oth tic event	To Be	17. Father's Name (First, Middle, William Amey	Last)					r's Name <i>(First, Middl</i> e, Thompson	Maide	n Surname)	-	
	nd 2 should ealth and N n 27 is ma er trauma	1 5	19a. Informant's Name/Relations Mrs Rochelle L		ıter				r or Rural Route Numbe sadena MD 2			o Code)	
Baltimore,	Page 1 arment of Ha ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (3		ce	metery, crem	sition (Name of atory or other place Cremato	e) ry	May 19, 2010		Location - City or en Burnie		
Balt	permit. Departimont Import any inj		21. Attracture of Funeral Service	JUN M	14-	-			Singleton nd Ave. SW				1
and the same	Physician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line.	1 SF	. Do not ente		, such as c				Approximate Interval Between Onset and Death	
_	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):			-			( )	
<b>ያ</b> .	insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	conseque	ence of):							
9	icate be executed physician and is the burial-transit		that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):		·					
	tificate ing phy e as the	Med	IF FEMALE:	1									=
Box 68	requires that the death certific been signed by the attending p should be detached for use as	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o	Fetal	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year	
ds, P.O			Part II. Other significant condition	ons contributing to death bu	t not resul	Iting in the ur	derlying cause give	en in Part I.				the cause of death?	√n
of Vital Records,	has has	Completed	-				_	·	24a. Was a autop perfor	sy rmed?	prior to death?	topsy findings available completion of cause of	e
<u>ta</u>	iician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					(Check only one)			Daughter Residence	_
N Of V	ding Phys	ate: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pendir	1 ☐ Inpatier 28a. Date of injury (Month, Day,	2	R/Outpatient 28b. Time of injury	28c. Injury work?	_ 4 ∐ Nur at	sing Home 5 Resid			ify) Residence	2
DIVISION	To the Hospital or Attending Physiciam: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be	y - At hom (Specify)	ne, farm, stree		/es 2□ N				ral Route Number,	
	e Hospita 24 hours e Funeral bleted fille	Medical	(Check 2 ☐ Medical E	Physician: To the best of m xaminer: On the basis of exa Nurse Practioner: To the b	mination a	and/or investig	gation, in my opinior	n death occ	urred at the time, date a	nd place	e and due to the o	cause(s) and manner sta	ated.
	Vithin Some		29b. Signature and title of certifier	Mo			29c. License	number		29d. Da	ate signed (Month		
	8		30. Name and address of person of HAU	who completed cause of dea	ath (Item 2	23a) (Type, Pr	int)		35 Wertmuser		Mo	21157	
	Stat Registra	-	81. Date filed (Month, Day, Year)	32. gistrar	s Signatur	1. A	venue al		110000000000000000000000000000000000000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8,18 per fh g903 5-21-10 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 17 10: 10 AM COVER MARGARET 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner GOOD HOSPITAL SAMARITAN BALTIMORE 5. Social Security Number 8. Date of Birth 1928 (Month, Day, Year) June 6, 1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 F 81 Months Days Hours Vittondale, PA 283-24-3120 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore MD 1 X Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 Halcyon Avenue 21214 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) At Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Celstine Hopkins James Wray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1608 Lasalle Road, Forest Hill, MD 21050 Robert Cover, Jr./Son 20b. Place of Disposition (Name of Evans Funeral Chapel – Bel Air 20a. Method of Disposition May <sup>D</sup>†8, 2010 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 21. Si nature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician SEPSIS dis se or condition lting in death) Medical Due to (or as a consequence of): Examiner TRACT INFECTION CHENOWIN URINE Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury LACTIC ACIDOSIS

Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MEILLITUS DIABETES iis certificate has director, page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after death.
I Director: After this or in by the funeral dire မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N Japan 05/17/2010 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blvd. Baltimore, MD 2/239 SICAT NAASA 5(001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CARTER Physician/ JOHN 2010 7:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NURSING BALTIMORE WEST ARLINGTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 XM 2 □ F Months Hours Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 Widowed 4 Divorced Completed Year or Dates. 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) | Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20o-Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sethsemane Bart Ch Cem 21. Signature of Funeral Service License 22. Name and Address of Facility
0 Seph L Russ
2 2 2 2 W North Home, P 23a. Part J. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumanic OUHTS Medical Due to (or as a consequence of): Examiner Atherosclere Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): arcinomo that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as 1 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No the Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires twithin 24 hours after death.

To the Funeral Director: After this certificale has been sign 2 No 3 Probably 4 1 Unknown Completed rania page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗶 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 2 🛣 No ည 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number Gonden My Klocem MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A M HTILL N NAEM 501 DLPHIN

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrat's Signature

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) Q

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number

10-03651 UNK UNK	n	nel Carraway  Please Type or P	rint in Black Ind Maryland / Depar				egible		-
		- For State Registrar		ificate of De			Reg. No.	2010	15331
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)			G	2. Date of Do Month	Day	Year	3. Time of Death 0359 hrs
Wedical Examili	_	Michael 4a. Facility Name (if not institution, give street	Antonio et and number)	4b. C	Carraway ty, Town, or Location			County of Death	
		Sinai Hospital		Ba	Itimore				
Funeral Director	- 1	5. Social Security Number 6. Sex	7. Age (In yrs. las	M	Under 1 Year If Und onths Days Hour	1 5 0			hplace (State or Foreign untry)
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yland a-f sho	핡	MD NA  10e. Street and Number		Baltimo	Zip Code		100 Citize	en of What Coun	1 X Yes 2 No
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tani: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be nexified at once.	Director		troot	1.01	21215		10g. Olii2	U.S.A	
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and 2 sho ealth and tem 27 is	-	James Carraway J 20a. Method of Disposition			Name of cemetery,	Ave Apt Date		Balt1 ocation - City or 1	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	n met		and Address of Facilit Ch F/H WE		o <sub>l</sub> Da	LIIIge	3117 BC
	4	23a. Part I. Enter the disease, or complication	os that caused the death.	4300	) Wabash	Ave, Bal	timo	re, Md	21215 Approximate Interval
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'60, ate be		IF FEMALE: 230	. If yes, outcome of pregna	ancy			23d.	Date of delivery	
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'Vit; 'hysici	<u> </u>	examiner? 1 ✓ Yes 2 No	i inpatient 2 V E	R/Outpatient 3	DOA Other	Nursing Home 5			
Division of Vital Records, tat or Attending Physician: The law requirers after death.  al Director: After this certificate has been side in by the funeral director, page 2 should		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month Day Year)	28b. Time of Injury 0329 hrs	28c. Injury at Work 1 Yes 2 ✓	. Subject wa		y occurred	
Divisation At urs after d	Certification:	3 Suicide 6 Could not be	8e. Place of Injury - At hom Specify) Local Street		tory, office building, et	or Town,	State)	d Number or Rura a Avenue, Balt	al Route Number, City timore, Md.
	Medical C	one) 2 Medical Examiner: On the	the best of my knowledge e basis of examination and						
5 . ½ 6 Ø	ŝ	29b. Signature and title of certifier	nanner stated.		29c. License number	<del></del>		ate signed (Mon	th, Day, Year)
		Yamela / withall,	mo		O.C.M.E.		May	12, 2010	
4	ſ	30. Name and address of person who comple Pamela E. Southall, MD Ass	eted cause of death (Item 2 istant Medical Exam	,	nn Street, Baltim	nore, MD 21201			
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	a. N. S					

			1 - State Of Mary Registrar		artment of H rtificate of L		, ,	iene eg. No. 2	1 :5335
	Physicia	212	1. Decedent's Name (First, Middle, Last)				2. Date of Death	n Day Year	3. Time of Death
200	/Medic			ssell			May 14	,2010	6 PM <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
	Francis		3916 Woodridge Rd  5. Social Security Number 6. Sex 7. Age (III	n yrs. last birthday)	Balti If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	
	Funeral Director		219-30-6860 1	V	Months Days	Hours Min.	8. Date of Birth (Month, Day, April		rthplace (State or Foreign ountry) MD
	land ow			c. City, Town or Loc	cation				10d. Inside City Limits
	Mary	ţo	MD n/a	Balti	imore				1 □XYes 2 □ No
	or 28g	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What C	ountry?
	th wit	la [	3916 Woodridge Rd.		21229	1		USA	
920	J within 72 hours atter death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Exp. direct must be redified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes ② ☑ Wolling Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba 1 □Yes 2 1 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
21215-0036	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done d DO NOT use retired,	ation luring most of work	ing	16b. Kind of Business	/Industry
212	I withi giene. r thar	mo	Elementary/Secondary (0-12) College (1-4or 5+)	1	elder	,		Baltimo	re Citv
b	it it je	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, N		
/lar	و و ت خ	To E	Lawrence Cassell			Anna	Hayes		
Maryland			19a. Informant's Name/Relationship (Type. Print)		•			City or Town, State,	
	s 1 and 2 of Health Item 27 I		Sam Cassell (grandson)					o,Md. 21	
Baltimore,	of the		I burial 2 perenation 3 bremoval from State	Place of Dispose cemetery, cremetery, cremet	ount Cre	matory	17,2010	20c. Location - City o	re,Md.
Bal	permit. Pag Department Important: I any Injury o		Signature of Funeral Service Licensee	- Tall 1	Name and Addres Calvin B 1412 E.	Scrug Preston	gs Fune	eral Home	e 2 <b>1</b> 213
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Co	V Ones	Art	ey In.	Seure	Onset and Death
-	/Medical Examiner		resulting in death)  Due to (or as a co	ensequence of):			, ,,,	100	
		ē	Sequentially list conditions, it any, leading to immediate	neequence of):					
	cuted ansit	Examiner	Sequentially list conditions, if any, leading to hims state cause. Enter Underlying Cause (Disease or injury that initiated events c.						
o,	an ar	Exa	resulting in death) Last Due to (or as a co	onsequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical	d						
			IF FEMALE:						1
Box	eath cert attending for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Vec 2 No. 1	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
0	that the de ned by the a detached t	ysi	1   Yes 2   No 9   Unknown						
α, σ,	res that signed to be deta	by PI	Part II. Other significant conditions contributing to death but no	ot resulting in the un	nderlying cause give	n in Part i.	23e. Did tob	acco use contribute	to the cause of death?
ğ	w require been signature should be	ed					1 □ Ye	s 2 □ No 3 □ F	robably 4 Unknown
Division of Vital Records,	e la e 2	Completed					24a. Was ar autops; perform	ned death?	sutopsy findings available completion of cause of
ital	30 1	BeC	25. Was case referred to medical examiner?			26. Place of Deat	1		s Z LINO
<b>)</b>	Physician: r this certific ral director,	2	- Hospital	2 ER/Outpatien	t 3 DOA Othe	r: 4 ☐ Nursing Ho	ome 5 🕅 Reside	nce 6 ☐ Other (Sp	ecify)
ion o	ding 1. After fune	ation:	27. Manner of Death  1	28b. Time of Injury	Work	rat ? ⁄es 2 ∐ No	28d. Describe ho	w injury occurred	
Divis	e Hospital or Attend 24 hours after death 9 Funeral Director. / letely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
	To the Hospita or Attenswithin 24 hours after death To the Funerall Director, completely filled in by the	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of example and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of gertifier	7 111	29c. License	number	25	9d. Date signed (Mor	th, Day, Year)
		1	Helpery & Cil	e UVV)	NO	10215	12	5/17	110,
			30. Name and address of posts (why completed cause of death	(Item 23a) (Type, F	96 IN	W.	3949	tinous &	me, 212)
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's	Signatur	1		- Carl	and the same of th	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Che	eryl Annette (		uge 1- For State Registrar	State	of Marylar		epartm <i>Certific</i>			and	Ment	al Hyg		Reg. No.	201	0	533
Me	Physicia dical Exami	an/	Decedent's Name (First,	Middle,Last 1ette	Caroug	e							Date of Dea Month May 15, 2	Day	Year	3. Time of 0835	
			4a. Facility Name (if not in:	titution, give			-	4	b. City, Town	n, or Lo	ocation o		Way 15, 2	4c. (	County of Dea		
	e		St. Josephs Hosp  5. Social Security Number	ital 6. Se	v I7	Age (In	yrs. last birt	hday)	Towson If Under 1	Year	If Under	r 24Hrs	8 Date of B		Itimore Co		te or
	Funeral Director		212-70-2102	1		. Age (III	54	Yrs.		Days	Hours	Min.	Aug.		Fore		
			Usual Residence of Deced	ent												Trois is	
	ow any		Maryland Ba	<sub>unty</sub> ltimor	`e	10c.	. City, Town Towso		on								City Limits
	aryland 8a-f show at once	Director	10e. Street and Number						10f. Zip Coo	de				10g. Citize	n of What Co		
1	er death with the Maryland , or items 23a or 28a-f sho		125 Othorid	je Roa	ıd				2	109	3				U.S.A	,	
3	ath with tems 2.	Funeral	11. Marital Status  1 Never Married 2	Married	12. Was Dece Armed For	ces?			Decedent ones, specify Co					0- 14	4. Race - Ame White, etc.	rican Indian,	Black,
	fter de:  ", or i			Divorced	1 Yes If Yes, Give Year or Dates:	2 <b>X</b>	No	1	Yes 2	No	s <i>pecify</i> :			s	pecify: Wh	ite	
	hours a matura	ed by	15. Decedent's Education		ly highest grade				's Usual Occ					16b. Kin	nd of Business	/Industry	
	36 hin 72 e. than "j	Completed	Elementary/Secondary (	0-12)	College (1-7	1 or 5+)	P	harma	acist					Ph	armecu	etical	
	5-00 led with Hygien other		17. Father's Name (First, M									,	irst, Middle,		,		
	121 Id be fi Aental J narked event,	Be Be	Gilbert Mor			_	19	n Mailing	Address (S	_			Caroli		or Town, Stat	e Zin Code)	_
	, MD 21215-0036 and 2 should be filed within 72 hours aft eath and Mental Hygiene. ten 27 is marked other than "natural" reaumatic event, the Medical Examins	은	Wayne Carou				1	25 O	thorid	ge	Road	To	wson,	Mary	land	21093	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be potified at once.		20a, Method of Disposition  1 Burial 2 X Cre	nation 3	Removal from		cremat	orv or oth	tion (Name o er place)		· ·	5/21/	Date 2010		cation - City o		
	Baltimore, permit. Pages I an Department of Hea Important: If itelinjury or other tr		4 Donation 5 Ot	er Specify:		-	HILITO		vice C								
	Balt permit. Depart Impor injury		21. Signature of Funeral \$	INFOR LICEIN	12	_			50 Yorl						eral H nd2120		nc.
	Physician		23a, Part I. Enter the disea failure. List only one			ised the	death. Do no									Approxim	nate Interval Onset and
	/Medical Examiner		Immediate Cause (Final di or condition resulting in de		Mixe						idol.	, oxy	codon	e, &	fentan	y1) □	eath
			Sequentially list conditions	h	ode to (or as a c	oriseque	nce ory. III	COMI									
		niner	if any, leading to immediat cause. Enter Underlying (	ause	Due to (or as a c	or seque	noa of):										
	ed nsit	Examine	(Disease or injury that initi events resulting in death)	Last [	Oue to (or as a c	onseque	nce of):										
	O, e be executed rsi cian and burial - transit	edical	X UNPENDED		AMENDED 2	7 20.		- ME	~0.03	E / C	05/10	) mm				<del>                                     </del>	
	760, icate be exphysician the burial	/Mec	IF FEMALE: 23b, Was decedent pregna	at in the	23c. If yes, ou	itcome of	pregnancy	r ME	g903		7				Date of delive		
	Box 6876( e death certificate the attending phyself for use as the b	Physician/M	past 12 months?	it iii tile	1 Live bir		of death 5		al death ner (Specify)	3	Ectopic	pregnand	у	M	Ionth	Day	Year
	BO) ne death the att	hysi	1 Yes 2 No 9	Unknown	9 Unknow		. "						Log- Did			45-2	dont 0
	F.O. Baires that the de signed by the	ē	Part II. Other significant of	onaitions	contributing to	eath but	not resulting	g in the ur	nderiying cau	ise giv	en in Par	τι.	1 Ye		e contribute to		
	Division of Vital Records, P.O. tal or attending Physician: The law requires that the rather death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed											24a. Was			utopsy finding	
	eco he law ate has age 2 s	dmo						-					perfe	ormed?	death?		
	Vital Rec ystcian: The l his certificate l director, page	BeC	25. Was case referred to n examiner?		conital:					_	bos	Check on					
	Physic Physic er this	은	1 ✓ Yes 2 N 27. Manner of Death	<u> </u>	ospital: 1 In	oatient Injury		utpatient Time of In			ther <sub>4</sub>	Nursing I	Home 5 3d. Describe	Residence		ir.	
	ion of tending Ph eath.	tion	1 Natural 5	Pending	(Month, E	Day,Year) 15/1(	1	7:51	`		s 2 X	No.	ınk				
	Divisi pital or Att ours after de ceral Direct	Certification:	2 Accident 3 Suicide 6	Investigation Could not be	28e. Place	of Injury	- At home, fa		t, factory, offi	ice buil	lding, etc			(Street and State) 12	Number or R	ural Route Ni	umber, City Rd
	Ospital l hours uneral ly fillec		4 Homicide 29a. Certifier 4 Certifie	determined	(Specify) an: To the best		nd at			o data	and place	1	uther	VILLE	e, MD		
	Division of Vital Records, P.O. Box 6876i To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	10110011 Olay	-	On the basis of and manner sta	examina											
	F 3 F 8	ğ	29b. Signature and title of	ertifier					29c. Lic						ite signed (M	onth, Day, Yea	ar)
			20 Name and address of	) L	ompleted	of do-"	(Itam 22=)			.C.M.	.E.		_	May 1	16, 2010		
			30. Name and address of p  Donna M. Vincen		Assistant Me			111	Penn Stre	eet, E	Baltimo	re, MD	21201				
		tate	31. Date filed (Month, Day,	1 8 20		istrar's S	ignature	6.	v.					-			
	Regis	ıralı	MAJ_	TO ZU	III John	ena	J.	for a	Kel					-			

DHMH 17 Rev 1/2001 OCME 2006

OCME

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 05:35 NWOOD 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hopkins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 65 Hours Min 214-38-9802 MD Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore NA MD 1 Yes 2 No 10f. Zip Code 21213 10e. Street and Numbe 10g. Citizen of What Country? 2820 Lake Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1∕2 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etcAfrican þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: American 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Security Company Security 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surpame)
Rlanche Watkins 17. Father's Name (First, Middle, Last) ပ္ Blanche Andrew Lee Davis 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 2400 Gainsborough Court Apt. "A" Baltimore Linwood M. Davis, Jr. 20a. Method of Disposition
1X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Garrison Forest 05-24-10 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. Signature of Funeral Pervice Licenses 638 N. Gilmor Street Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death negative bacteremia Physician/ Gram days disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year this certificate has been signed by the ral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 🗌 Yes 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural s after dea. ral Director: After 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral C

completed filled i

State

DHMH 17 Rev 7/2009

Registrar

Medical

only one)

auren Block, Johns

31. Date filed (Month, Day, Year)

auen Bloch, medical doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. R gistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

2010

21224

29c. License number

Hopkins Bayview Medical Center, 4940 Eastern Avenue

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #9, 15, 17 per Inf G903 5/25/I0 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Dear ranklin mac 9010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner allaway 1arus Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** 6. Sex Birthplace Country) Alabama Months Days Hours Min. 1⊠M 2□F 19 1936 Director 419-46-7474 73 Aug Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Leonardtown 1 ☐ Yes 2 No MD St. Marys Funeral Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or items or other traumatic event, the Medical Examiner must be not 20650 22271 Pt. Lookout Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1957 – If Yes, Give Year or Dates: 1977 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) active duty US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moultia Dean Florence Bell Brown Moltie Dean ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Dean/spouse 22271 Pt. Lookout Road; Leonardtown, Maryland 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) 21. Signature | Funeral Cona Lo S Wad <sup>22</sup>State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia C use (Final disease or condition resulting in death) **Physician** 17 Kinson ar /Medical D e to (or as a consequence of): Examiner Sequentially list conditions, if a probability of the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequency of or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 🗌 Yes 2XI No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) HOSPICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this HILLSR funeral c 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury ours after death. neral Director: Af filled in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and may her stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Months

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Bring in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, 2010 5:40A Doolittle Jeffrey Edwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Youne 10) Months Days Hours Min. New York **Director** 460-64-9334 1943 66 June Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Texas Harris Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? è "natural", or items 23a or Funeral 77373 United States 5903 Fairway Manor Lane hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 No 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Continental Airlines Elementary/Seconday (0-12) College (1-4 or 5+) Power Train & Air Frame 4 Mechanic Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles Doolittle Margaret Roxana Weeks 19a. Informant's Name/Relationship (Type, Print)
Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Doolittle/<del>daughter</del> 11634 Log Jump Trail Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) inal Journey Crematory 5/17/2010 Woodbine, Maryland . Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 thomas ptinou M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastanc disease or condition resulting in death) wainoin LNS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed bunial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical Box 68760 for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death Yes the a 1 ☐ Yes ∠ ⊆ 9 ☐ Unknown a 🗌 Unknown P.O. signed by t Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 🗆 No 3 🗔 Probably 4 🛱 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Was an autopsy performed? Hospital or Attending Physician: The law page 2 has certificate 25. Was case referred to medical examiner? **Division of Vital** funeral director, æ 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 🗀 Residence 6 💆 Other (Specify) Hospital: 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide iniurv 5 Pending after death. 2 No Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

10-03612 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene George Alan Etter Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day May 10, 2010 1505 hrs **Medical Examiner** Alan Etter George 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 3228 Tartarian Court Lansdowne If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreian Months Days Hours Director Country) 218-70-2307 1 X M 2 F 53 Yrs. 10,1956 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Ealtimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f oberinjury or other traumatic event. The Maries I. Baltimore Lansdowne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3228 Tartarian 21227 United States Court Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? ( Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes White 3 Widowed 4 X Divorced Yes. Give Year 1 Yes 2 X No specify: Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Unemployed Unemployed 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Ira Barr/ Minister-Friend 1201 Maple Ave. Arbutus, Maryland 21227 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/15/2010 Glen Burnie, Maryland Atlantic crematory 4 Donation 5 Other Specify: 22. Name and Address of Facility  $\mbox{AMBROSE} \ \mbox{FUNERAL} \ \mbox{HOME,INC.}$ 21. Suprature of Funeral Service Licensee Tatular am Delatata 1328 Sulphur Spring Rd. Arhufus MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Mardica) Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical X UNPENDED AMENDED 23a, PII, 27, per ME g904 6/18/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Chronic alcoholism 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death?

Records, P.O. of Vital

certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director;

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Certification:

Medical

1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 Other: Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1XX Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29c. License numbe 29d. Date signed (Month, Day, Year) OCME O.C.M.E. May 11, 2010

36. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registra

Theodore M. King, Jr., MD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17perFH, G903, 5/2072010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 19b, per Inf G904 6/2/10 TT. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13<sup>Pay</sup> Menth 5 Physician/ 20 Î Ö 2:30 pm Anthony Eckels Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** na Baltimore 5939 Glenkirk Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours Min. Month, Day, Year, 7 Country) MD Director |218-46-6554 62 Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No Baltimore MD na 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral SA 21239 U 5939 Glenkirk Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Page 1 and 2 should be filed within 72 hours after dear ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or iter jury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12th grade Brake Press Operator Be Taher's Name (First, Middle, Last)
- Albert Eckels 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ethel Mae Ennis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2363 Perring Manor Road Balto, MD 21234 19a. Informant's Name/Relationship (Type, Print) Beverly Cash-Eckel -Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place; Arbutus Memorial 5-19-2010 Arbutus, MD 21. Signature of Fun ( Service U 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due equence of ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for Month Year Day 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? this certificate 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital 2 110 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending s after death. М Accident Investigation completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a To the Hospital Medical 29a. Certifie Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature ap title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name a dress of person ho completed ca ise of death (Item 23a) (Type, Print) ORE 31. Date filed (Month, Day, 32. Registrar's Signature State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31 per DVR g903 5/18/10 TT
State of Maryland 7 Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Day 11 A M <u> Viola: Josephine Fuentealba</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A . Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 1 🗌 M 2 🛛 F Months 219-16-9533 04-01-1925ear Director 85 Maryland Usual Residence of Decedent or 28a-f shov 10a, State 10b, County death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 4501 Arabia Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married "natural", or þ 1 ☐ Yes 2 💢 No If Yes, Give permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Henderson Mary w. Look 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21286 Mrs. Victoria Jenkins - Daughter 1570 Cottage Lane 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05-18-2010 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road [Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ensic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): tibrillatic attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical vascuelar coaculation Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No been signed by the atte should be detached for 5 Other (specify) Month Dav Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 2 🗌 No 1 Tyes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 🗷 No ၉ 1 

Inpatient 2 

ER/Outpatient 3 

DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 📙 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES -000 MD 05,11,2010 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital 5601 Loch Raven Blvd Baitimore MD 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

<del>05, 11, 2010</del>

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:30 A M Joan Grace Fitzgerald May 14 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 1 F 74 216-32-2957 11/12/1935 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No MDCarroll New Windsor Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a 4019 Franklinville Rd. 21776 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 本本No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes XX No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Her Home 8th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph LaRicci Anita Udes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Paul Fitzgerald (husband) 4019 Franklinville Rd. New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem 5/18/2010 4 □ Donation 5 □ Other (Specify) Finksburg, MD 21. Signature of Fundame Ser Burrier Oueen Funeral Home and Crematory 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -ung Chace disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transi Due to (or as a consequence of): physician the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 2 No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed 25. Was case referred to medical examiner? 26. Place of Death Check onl one To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 10 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. within 24 hours after death

To the Funeral Director:
completely filled in by the

3altimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Suicide

4 Homicide

6 Could not be determined

Registrar's Signatu

Registrar

			For State of	Maryland / Depa	artment of Health and	•	
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of Death	2. Date of Deat	eg. No.
igh 6	Physicia Medic	cal	HORACE GAIL  4a. Facility Name (if not institution, give street and number		I	May	12°, 2010 11:30P M
	Examir	ner .	Haven Nursing Home	9	4b. City, Town, or Location of Dea Baltimore	tn	4c. County of Death
Ī	Funeral Director		5. Social Security Number 6. Sex 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) MD
	now at	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Marylar r <b>28a-f s</b> notified	Funeral Director	MD Baltimore	Gwynn	Oak		1 ☐ Yes 2 🗓 No
	s 23a or	neral [	10e. Street and Number 3604 Oak Avenue		10f. Zip Code 21207	1	0g. Citizen of What Country?
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	2	11. Marital Status  1 Never Married 2 Married 2 Married  1 Never Married 2 Married 2 Married  1 Never Married 2 Marr	□ No	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🂢 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. SpecifiAfrican—American
21215-0036	within 72 hou gjene. <b>ier than "nat</b> <b>ier the Medica</b>	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4)	I (Give	dent's Usual Occupation kind of work done during most of wo O NOT use retired) ping Clerk	orking	16b. Kind of Business Industry Helma Transportation Co.
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	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Deboraha Gail/ Daughter		ng Address (Street and Number or Ri Oak Avenue, Balto. M		City or Town, State, Zip Code)
Baltimore,	age 1 and ent of Heal nt; If item 2 y or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St. 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren	matory or other place)		20c. Location - City or Town, State Owings Mills, MD
Balti	permit. Page 1 a Department of I Important; If it any injury or of	-	Signature of Funeral Service Licensee	22	2. Name and Address of Facility W	ylie Fu	neral Home P.A. dallstown, MD 21133
	_		23a. Par 1. Enter the disease, or complications that cau				
~	Physician/ Medical	1	Immediate Cause (Final disease or condition republic in death)	line.  OSCIECTIC  as a consequence of):	Cardiovaso	clar di	Interval Between Onset and Death
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	uted	Examiner	flam, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	ac a combequence cij!			
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68760	ficate g phys as the	Jedi	_ u				
. Box 68	Attending Physician: The law requires that the death certificate ar death.  **T death.**  **Ector.** After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Physician/Med		th 2 Fetal death 3 to at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ls, P.O.	uires that th signed by Ild be detac	ρ	Part II. Other significant conditions contributing to deat  Multiple dece	h but not resulting in the u	inderlying cause given in Part I.		acco use contribute to the cause of death?  s 2 □ No 3 □ Probably 4 🗗 Unknown
Division of Vital Records,	The law require sate has been si page 2 should	Completed	Dementia			24a. Was an autopsy perform	prior to completion of cause of death?
a	i <b>ician:</b> The certificate ector, pag	Be C	25. Was case referred to medical examiner?		26. Place of Death (Che		A NO TE les 2 E NO
Ξ	Physician: this certific al director,	2	1 ☐ Yes 2 🕅 No Hospital: 1 ☐ Inp	atient 2 ER/Outpatien		Home 5 Resider	nce 6 Other (Specify)
on of	ending P aath. or; After t he funera	Certificate:	2 Accident Investigation	njury 28b. Time of Day, Year) injury	28c. Injury at work?  M 1 Yes 2 No	28d. Describe hov	v injury occurred
Divisi	e Hospital or Attend 124 hours after death e Funeral Director; A lleted filled in by the f	al Certi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	Injury - At home, farm, stre etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completed filled in by the funeral	Medical	29a. Certifier (Check only one) 1 A Certifying Physician: To the best 2 Medical Examiner: On the basis of Certifying Nurse Practioner: To the basis of Certifying Nurse Practioner: To the basis of Certifying Nurse Practioner:	f examination and/or invest	tigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier  The Amalian H LOCCE	m mp	29c. License number  D / 550		Nay 13 2010
			30. Name and address of person who completed cause of AMATUH MINACEM	f death (Item 23a) (Type, P	PITIN STR R	Baltimo	me MD 2/2/7
	Stat Registra		31. Date filed (Month, Day, Year) 32 Regis	strar's Signature	alla		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Giordano а м 2010 7:34 Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Circle Baltimore 16 Airway Towson 1-A Apt. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Months Hours 94 MD **Director** 094-22-8477 15 - 1916Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director Towson Baltimore Md 1 🗌 Yes 2 🏻 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or items 23a o Funeral 21286 U.S.A. 16 Airway Circle Apt.1-A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Adolf's Barber is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giordano Alfonso Rose Furnari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and com.
Department of Health an Important: If item 27 is 5203 Falls Road Terrace Balto. Md. 212<sub>10</sub> - Son A. Joseph Giordano 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Memorial 20a. Method of Disposition 20c. Location - City or Town, State Aberdeen, Maryland 1 X Burial 2 Cremation 3 Removal from State 5-19-2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility  ${ t Joseph}\,\,\, N$  . Zannino Jr. Conkling St. 21224 263 S Balto. 23a. Part 1. Enter the dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failur. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physiciani onge disease or con ition resulting in de ith) 4.841 Medical Due to (or - a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transi Physician: The law requires that the death certificate be execute that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by ; page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}}\) 1 Residence 6 \(\text{\text{\text{Other}}}\) Other (Specify) 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21284 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		State of Ma	iryiand		tificate of D		іментаі пу	giene Reg. No.?	nin	15346
D	_	1. Decedent's Name (Firs		,					2. Date of De	eath	010	3. Time of Death
Physician Medica		Jeffr	a	j	R		Gellert		Month May	Day 16	Year 2010	03:15 AM
Examine		4a. Facility Name (if not in	-	street and number)			4b. City, Town, or		th	4c. C	ounty of Deat	1
	4	Fairfi 5. Social Security Number		ursing Home		to inthe aforms	Crownsv If Under 1 Year				ne Aru	
Funeral Director		219-38-558	3 1	EX 2 ☐ F	(In yrs. last 69	Yrs.	Months Days	If Under 24 Hr Hours Mir	. (Month, Da		Cou	hplace (State or Foreign Intry) .ryland
nd how	- 1	Usual Residence of Dece 10a. State 10b.	dent . County		10c. City, T	own or Loc	ation					10d. Inside City Limits
arylar la-f sl	Funeral Director	Maryland A	Anne Ar	undel	Pasa							1 🗆 Yes 2 🗐 No
or 28	፭፟፟፟፞፞፞፞	10e. Street and Number				acma	10f. Zip Code			10g. Citize	n of What Co	untry?
with s 23a ust b	era 	155 Woods V	Way				21122			Ţ	JSA	
leath items er m	돌	11. Marital Status		12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	Vas Decedent of His Yes, specify Cubar	spanic Origin? (	Specify Yes or No-	14	. Race - Amer	
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ 1		1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates.	lo		Yes 2 No		to moan, etc.)	Sp	Black, White becify: Wh	nite
2 hou	Bet		Decedent's Ed	ducation de completed)		(Give k	ent's Usual Occupa	ition uring most of we	orking	16b. Kind	of Business I	ndustry
121 tthin 7 sne. than	Ĕ [	Elementary/Seconday	/ (0-12)	College (1-4 or 5-	)		NOT use retired) employed	3	-		1. 1	,
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be fill he fil	의	Raymond	. ,		Gelle	rt		Josep	, ,	,	Jeff	ra
Nore, Maryland ge 1 and 2 should be file it of Health and Mental I : If item 27 is marked o or other traumatic eve	Ì	19a. Informant's Name/R	Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street a	nd Number or R	ural Route Numb	er, City or To		
	L	Jeffra Gel	llert	son		116 W	ater Four	ntain Wa	ay Apt 20	)4 Gle	n Burn	ie MD 21060
Ore		20a. Method of Dispositio 1 ☐ Burial 2 🖾 Cro		Removal from State	20b. Plac	e of Dispos	sition (Name of latory or other place		Date		ation - City or	
Limor Page 1 tment of 1 tant: If it		4 Donation 5 D	Other (Specify	()	Metr	o Cre	ematory I	nc. 5/	18/2010	Balti	imore M	laryland
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signatur of Funeral S	Service Vic ins	*			Name and Addres		Stallings			
	$\dashv$	23a. Part 1. Enter the dis shock, or heart fall	sease, or com	olidations that caused	he death. D	o not ente	111 Mount	ain Roa , such as cardia	ud Pasade uc or respiratory a	ena Ma rrest,	ryland	21122 Approximate
Physician/		Immediate Cause (Final	ure. List only de	ne cause on each line.	+	11			. ,	,	- 1	Interval Between Onset and Death
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3760 ificate bing physic g physic	Ned Aed	E EEMALE:										
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ord requ	lete								24a. Was	an	24b. Were aut	opsy findings available
ital Records, P.O. Bi sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed								auto		prior to death?	ompletion of cause of
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Aate of Death 3. Time of Death Physician/ 50 Medical institution, give street and nymber) 4a. Facility Name (if no 4c. County of Death Examiner OA 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 🗆 M 2 🛂 nth\_Day Director 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a. State 10c. City Town or Location 10d. Inside City Limits Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 21215-0036 1 🗌 Yes 2 🖳 No If Yes, Give Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Maryland 17. Father's Name (First, Middle, Last, ပ္ artment of Health and Men ortant: If item 27 is marke injury or other traumatic Informant's Name/Relationship (Type, Print) Town, State, Zip Code) 19b. Mailing Addresa Baltimore. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date Burial 2 Cremation 3 Remova rom State ation 5 Other (Specify) 4 Don 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira any arrest shock, or heart failure. List only one cause dy ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital ည 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending iniurv 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ess of person who completed cause of death (Item 23a) (Type, Print) 6 1200 C 31. Date filed (Month, Day, Year) Registrar

10-03575 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Green, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day 9, 2010 0850 hrs Medical Examiner William Jr. Green 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore City** 2438 East Biddle Street NA 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Director 09 - 20 - 51218-60-3648 58 MD 1 XM 2 F Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No item 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at once. MD NA Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2438 E. Biddle Street 21213 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black White, etc. African Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced Yes, Give Year Specify: American ģ Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 12th Grade NA Self-employed Home improvement 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William L. Green, Burgess Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Street Baltimore, Lynette Green-Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date tant: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05-17-10 Baltimore, MD Trinity Cem. ortant: Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service License Wylie Funeral Home Street Baltimore, MD N. Gilmor Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical a. Hypertensive Cardiovascular Disease Death Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit Physician/Medical attending physician a or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown For Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Renal Failue Status Post Transplant; Diabetes Mellitus Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 ✔ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 V Natural 1 Yes 2 No Pendina filled in by the To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be (Specify) Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 12, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. 32. Registra s Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Altha Iola Gragg May 14 2010 9:42 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F Director Tennessee 213-20-2366 91 18, 1918 Dec. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits the Medical Examinar resist be notified at Director 1 XYes 2 □ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 300 Sunflower Drive Apt. 157 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 0, 1 ☐ Yes 2 🛣 No Specify: ð Specify: 3 Widowed 4 ☐ Divorced Year or Dates: "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 9 Telephone Operator 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fill lealth and Mental F Hillary McDougle Edmondson Mary Rebecca Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 an Department of Heat Important: If Item 27 any injury or other tr. once. Patricia D. Brown / Daughter 338 Frenchtown Rd., Elkton, MD 21921 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5-17-10 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** conce OM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner inknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Dav 5 Other (specify) 9 Unknown nuer uns certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 200 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Medical Certification: To 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and ad re-

DHMH 17 Rev 1/2001

31. Date filed (Month, May, Year) 32. Registrar's Signature

Bluem Keld

o pers n who complete

J. Jak

520 Upow Chasapeake Dr Juite 412 Bel Av, MD 21014

cause of death (Item 23a) (Type, Print)

Chr

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 5, **Physician** Carole Ann Green 2010 10:30 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 215 Sullivan Road Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F New York 067-32-5284 70 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, if a Medical Evaning India to require the confined. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Westminster Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Sullivan Road Completed by Funeral 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva Weaver Clarence Edward Farley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Sullivan Road; Westminster, Maryland 21157 Sharon Myers/caretaker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signa ure of Funeral School Ce Licensee <sup>22</sup> State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate ourse (Final disease or condition resulting in death)

a. Moccordial Transfer **Physician** /Medical Due or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Consertive 24a. Was an autopsy performed? Yes 2.27No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number H53939 many 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Imance 1, Do ; 212 washington Heights Med Ctr; Westminster, MD

State Registrar 31. Date filed (Month, Day, Year)

32. Regist ar's Signature

P.O. of Vital Records,

Division

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≧	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal dea	ath 3 Ectopic preg	nancy	Month	Day Year
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	27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
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≌	one) 2 Medical Examine	r: On the basis of examination	and/or investigation, in	my opinion, death occurred	at the time, date an	d place, and due to	the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar

and manner stated

32. Registrade Signature

29b. Signature and title of certifier

Ling Li, MD

hu,

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29d. Date signed (Month, Day, Year)

May 10, 2010

MD

Md

Death

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	State of Maryland / Departs	ment of Health and	t Mental Hygiena

Julio Torrez Gonza	1	- For State	St	ate of	Maryla	nd / l	Departme <i>Certifica</i>		Health an Death	d Men	tal Hyg		a No	2010	15352
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	ľ	4a. Facility Name (in University H		on, give str	eet and nui	mber)		ľ	b. City, Town, or Baltimore	Location of	of Death		40	County of Deat	h
Funeral	٩.	5. Social Security N		6. Sex		7. Age (	In yrs. last birtl	nday)	If Under 1 Yea	r If Unde	er 24Hrs.	8. Date of Birt	h(MM/	N/A	rthplace (State or
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after doperativent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner management of the Roman Commission of the Files.		19a. Informant's Na							Address (Stree	et and Num			ber, Ci	ity or Town, State	
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Baltimore, permit. Pages 1 as Department of He, Important: If ite		4 Donation 5	Other S	pecify:			Hillto	p Se	ervice C	orp.	5–17-	-2010	To	owson	Maryland Home, Inc.
Ball permit Depar Impor		21. Sture of Fur	11/					22. N	ame and Address 50 York	Posd	Ruck	k Towso	n F	Funeral	Home, Inc. 1204
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ViSi or Att fler de Directe in by t	3	2 ✓ Accident 3 Suicide		stigation L	28e. Place	of Injury	/ - At home, fa	m, stree	t, factory, office b	uilding, etc	c. 28	or Town, St		nd Number or Ru	ıral Route Number, City
Di spital ours a ours a filled		4 Homicide	dete	rmined	(Specify)	Local	Street		<u>-</u>		12			Howard Street	, Baltimore, MD
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me		Oncon only		miner:On		f examin			ed at the time, da on, in my opinion						
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<i>'</i>		Victor Weed 31. Date filed (Monti		Assis	tant Med		xaminer Signature	111 P	enn Street, B	aitimore	e, MU 21	1201			
State Registra	~	Date med (MONU	AY TQ	2010	2.00	giou al S	o ignature	bar	Kel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month 2010 Kenneth C. Hoke, Jr. May 6:00 AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 69 Blythedale Road Cecil Perryville 6. Sex 1 M M 2 □ F Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Hours NOV 23 District of Columbia Director 218-58-1408 54 Usual Residence of Decedent or items 23a or 28a-f short 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Perryville 1 🗆 Yes 2 🗶 No M Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 69 Blythedale Road 21903 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Force 1 ☐ Yes 2 X No If Yes, Give ģ 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Boiler Engineer Hospital permit. Page 1 and 2 should be filed of Department of Health and Mental Hyg Important: If item 27 is marked othur any injury or other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) C. Hoke Kenneth Pine11 Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 Blythedale Road Darcy A. Hayes, daughter Perryville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metro Crematory, Inc. 05/18/10 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road 21228 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performe After this certificate 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 \( \triangle \) Nursing Home 5 \( \triangle \) Residence 6 \( \triangle \) Other (Specify, ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation after death 6 Could not be 24 hours after de Funeral Directo leted filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 219

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

10-03625

Clifton Harris	1-For State Certificate of Death											
Physician/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Anoth  Pay Year	_										
Medical Examiner	CLIFTON HARRIS May 11, 2010 0517 hrs  4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
	Prince George's Hospital Center  Cheverly  Cheverly  Prince George's											
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	_										
Director	578-78-6344 1 M 2 F 52 Yrs. Months Days Hours Min. 10/18/1957 Foreign Country) VA											
<b>A</b>	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits	_										
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Aaryland 184 once.	MD Prince Georges Ft. Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country?	_										
ith the Maryland 23a or 28a-f sho notified at once, al Director	202 Warburton Oaks Dr. 20744 USA											
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rs afte ural", miner	3 Widowed 4 X Divorced If Yes, Give Year 1977 1986 1 Yes 2 No specify: Specify: Black  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry											
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212' tould be d Mental s marke tic event To Be	Martin Grant  Bettie Harris  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
AD 2 sho	Ericka Harris - Daughter   231 Winters Ct. Clarksville, TN. 37043											
re, land f Heal	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 1 Cremation 2 Town, State 2 X Cremation 3 Removal from State 3 X Cremation 3 Removal from State 3 X Cremation 3 Removal from State 3 X Cremation 3 Removal from State 3 X Cremation 3 Removal from State 3 X Cremation 3 X											
imo Page: ment o tant: ]	Metropolitan Crematory 5-15-2010 Alexandria, VA.											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medica To Be Comple	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Marshall's Funeral Home of Maryland											
Physician	4308 Suitland Rd. Suitland, MD. 20746 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva											
Madient.	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries Between Onset and Death											
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To cor	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	┨										
	(la (1) 1 1 1 1 1 0.C.M.E. May 12, 2010											
<u>,    </u>	30. Name and address of person who compreted cause of death (Item 23a)	٦										
	Zabiullah Ali, M.D. Assistant Medical Examiner / 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)   32. Registres Signature	4										
State Registrar	31. Date filed (Month, Day, Year) 32. Registrat's Signature  MAY 18 2010 Agree A. Sankar											
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	For State	State of Maryland	Department of F	lealth and Mental H	2010	I to the first free
	Registrar  1. Decedent's Name (First, Middle, Las	<u> </u>	Certificate of	2. Date of D	Reg. No	2 Time of Death
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/Medical	A	troot and number)	4h City Town o	r Location of Death	4c. County of Death	1.05 4
Examiner	St- Elizabeth	Nursing Ce	nter Bo	ultimore		
Funeral Director	5. Social Security Number 6. Se 214-14-4288	7. Age fin yrs. last	Yrs. If Under 1 Year Months Days	Hours Min. 8. Date of B	Day, Year) Cou	place (State or Foreign ntry) vland
D.	Usual Residence of Decedent					<i>y</i> 25
aryla show	10a. State 10b. County	10c. City, 1	own or Location			10d. Inside City Limits
Ne M	VA Fairfax		Fairfax Stat	ion		1 ☐ Yes 2 No
with the Man a or 28e-f sh be notified	10e. Street and Number 5716 Jonathan Mit	aball Dage	10f. Zip Code 2203	0	10g. Citizen of What Cou	ntry?
s 23	3/10 Johathan File				USA	1 2
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or Items 23s or 28s-1 show event, the Madical Exartli at must be notilized at Be Completed by Funeral Director.		12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.)  Specify:	14. Race - Ameri Black, White, Specify: White	etc.
2 hou		ucation 1	6a. Decedent's Usual Occup	ation	16b. Kind of Business/Ir	ndustry
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tal Hygind other ovent, I	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle	le, Maiden Sumame)	
				Lula Stoll		
S D E E	19a. Informant's Name/Relationship (T	ype, Print) 1	19b. Mailing Address (Street	and Number or Rural Route Num	ber, City or Town, State, Zij	Code)
and 2 ealth a n 27 (s	Janet Hunt Da	ughter	5716 Jonathan	Mitchell Road;	Fairfax Sta	tion, VA 220
- 主 る 章	20a. Method of Disposition	20b. Place	e of Disposition (Name of etery, crematory or other place	Date	20c. Location - City or To	
rages nent of l int: If it iny or o	1 🖫 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ry 5/18/2010	Baltimore, M	D
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Depa Impo eny ii	11/11	MA La	funeral H	ome of Catons∀1 ondson Avenue; C	lle, Inc.	MD 21228
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thin 24 hou the Fune impletely fil	(Check only 2 Medical Exami	sician: To the best of my knowled	age, death occurred at the tin and/or investigation, in my o	ne, date and place, and due to the pinion, death occurred at the time	e cause(s) and manner as s s, date and place, and due t	tated. o the cause(s)
thin the sample	29b. Signature and title of certifier	and manner stated.	29c. Licensi		29d. Date signed (Month,	
8 4 8 -		mon				
		1		3 3 391	May 14,	2010
eV	30. Name and address of person who c	ompleted pause of death (Item 23)	AUENUE,	55391 Baltimore	Maryland	2122/
State	31. Date filed (Month, Day, Year)	32. Rigistrar's Signature	8 6 40			
Registrar	MAI 182	IIU Deneva &	The state of the s			

			State of Maryl State Amend Items 15, 16a, b, 19	and / Department of Health a a,b per sa,g903,05/18/ Certificate of Death	nd Mental Hygiene 2010dhb Reg. No. 2 0 1 0 1 5 3 5 6
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	togben	2. Date of Death Day 09, 2010 1420 AM
	Examin	er		Hospital Rockville	Death 4c. County of Death Montgomery
	Funeral Director		and the second s	rs. last birthday)  If Under 1 Year If Under 24  Months Days Hours	Hrs. 8. Date of Birth Min. Feb 28, 1929  9. Birthplace (State or Foreign Country)unk
	aryland ka-f show ified at	Director	10a. State 10b. County 10c.	City, Town or Location Gaithersburg	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	h the M 3a or 28 be not		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wil	Funeral	101 Odendehal Avenue #806  11. Marital Status unk   12. Was Decedent Ever in	U.S. unk 13. Was Decedent of Hispanic Origin	USA  19 (Specify Yes or No-  14. Race - American Indian,
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatte event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, F  1 ☐ Yes 2 🛣 No Specify:	Puerto Rican, etc.)  Black, White, etc.  Specify: White
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212	d within ygiene. her tha nt, the l	as I	Elementary/Seconday (0-12)  unk 12  College (1-4 or 5+)  unk 8	Mathematics profess	
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, Maryland 21215-0036	and 2 should Health and N tem 27 is ma ther traumat		19a. Informant's Name/Relationship (Type, Print) <b>John Nazarian — Friend</b> Shady Grove Adventist Hospital	19h Mailing Address (Street and Number of 1990) 1 Medical Center	or Rural Pouts Number, City or Town, State, Zip Code 20877
altimore,	. Page 1 ar ment of He tant: If iter jury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ○ Other (Specify) in State	b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Ball	permit Depart Impor any in		21. Signature of speral Service en add, Mirect	32. Name and Address of Facility State Anatomy Bo Baltimore, Marvl	ard; 655 W. Baltimore Street
***************************************	Medical Examiner	Examiner	Due to (or as a cons	sequence of):  The trystical  sequence of):  The trystical  sequence of):	Ling di) cqic Interval Between Onset and Death
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. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of prediction in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
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Δ	e Hospital 124 hours le Funeral pleted filled	Medical	(Check 2 Medical Examiner: On the basis of examination	ation and/or investigation, in my opinion, death occu	and due to the cause(s) and manner as stated.  Irred at the time, date and place, and due to the cause(s) and manner stated.  Individually place, and due to the cause(s) and manner as stated.
	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (I	Item 23a) (Type, Print)	
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	Sta Registra		31. Date filed (Month Day, Year) 2010 32 Registrar's Sig	gnatury Carles	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day Year **Physician** Hackett 2010 AM Anne 5 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Maryland Masonic Home Baltimore Cockeysville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🗓 F 85 213-20-6486 Oct 18, 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 International Circle 21030 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify. Completed by 3 Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Metal Fabrication Executive Secretary n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 01ga Labeka John Gewera 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7858 2043 Sue Avenue, Baltimore, Ruth Ann Hackett/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/18/10 Baltimore, Maryland Oaklawn Cemetery bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD Approximate Interval Between Onset and Death 23a. Part1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he of failure. List only one cause on each line. Immediate Cause Final disease or condition or resulting in death) erebro Vas cular Diseise leis Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Undeade or highly that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 254No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 4 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Examiner requires that the death certificate be executed physician and sthe burial-trans Box 68760. attending p ed by the a P.0. been signed by the should be detach Records, this certificate has director, page 2: Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

**Funeral** 

Director

sa or 28a-f show t be notified at

"natural", or Items 23a edical Examiner must b

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical

**Physician** 

/Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Physician/Medical Completed by Be Certification:

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

29b. Signature and title of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

108 Bank ST. RUBERT LIBERTU 32. Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

filled in by the

Medical

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Catherine L. Howard 01:55 FM HAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Season Hospice-N.W. Baltimore Randlestown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 9 /8/146 Months Director 63 Usual Residence of Decedent or 28a-f shov notified at shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zin Code ò 10g. Citizen of What Country? ral", or items 23a о Examiner must be Funeral 319 S. Ballou Court 21231 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ş 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3℃Widowed 4 □ Divorced Completed Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self House Wife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Lawrence Ruffin Margaret Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Jackson/Daughter 1681 Woodbourne Ave, Balt., MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place)

Zion Cem 1 X Burial 2 Cremation 3 Removal from State 5/22/10 Balt.,MD Mt. 4 ☐ Donation அ☐ Other (Specify) 22. Name and Address of Facility Hari P. Cl 5126 Belair Rd, Balt., MD 21. Signature of Funeral Service Licens Close F.Svs.PA ID 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ 0 tructive hronic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 Po

9 Unknown been signed by the atte should be detached for Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy perform 1 🗌 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Stother (Specify) T, PT Hopping 2 XNo ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Dending work? 1 ☐ Yes 2 ☐ No Accident
Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6874 Aviabla BIVD 21061

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Barbara Ann Henry 16° 1 0 11:10pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 1 □ M 2 □ F Min Director 214-44-2364 62 5/29/47 MD Usual Residence of Decedent or 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3417 Juneway 21213 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, frican \$ 1 Never Married 2X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Completed Amer. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospice Home Provider 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Woodrow Sheppard Edith Marie Hall injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeisha Henry-Joyner/Daug 3150 Ebbtide Dr., Edgewood, MD 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/20/10 Balt., MD Zion Cem. <sup>22. Name and Address of Facility</sup>Hari P. CloseF.Svs,PA 5126 Belair Rd,Balt.,MD 21206-5105 21. Signature of Juneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ disease or condition Cana Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☒ No for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate l 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 \( \subseteq \text{Yes} \quad 2 \( \subseteq \text{No} \) 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

29b. Signature and title of certifier

MarianGom

31. Date filed (Month, Day, Year)

AUT. CKNS

6701

N.

Charl

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

29c. License number

ouson

R149194

MD

21204

29d. Date signed (Month, Day, Year)

1) 2010

DHMH 17 Rev 7/2009

State

Registrar

Baltimore, Maryland 21215-0036

68760

Division of Vital Records, P.O.

istrar's Signature

10-03	3622
Paul	lamnieri

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 1535 | State of Maryland / Department of Health and Mental Hygiene

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Physician		gistrar Decedent's Name (First, Midd	le,Last)									Date of De Month	Day	Year		Time of Dea 0111 hrs	
Medical Examine	er 💮	Paul Iampieri						_				May 11,		c. County o	f Death		
()	4	a. Facility Name (if not institution St. Agnes Hospital	on, give s	treet and nu	mber)				y, Town, or Itimore	Location o							
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21215-0036 Juld be filed within 7 Mental Hygiene. I Mental Hygiene. I werked other than te event, the Medica	ᆰ	19a. Informant's Name/Relation		pe, Print )			19b. Ma	iling Add	iress (Stre	eet and Nur	mber or R	ural Route N	lumber,	City or Tow	vn, State,	Zip Code)	)111
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Baltimore, semit. Pages I an Department of Hea Important: If ites	t	21. Signature of Funeral Servi	e Licens	ee			i	2. Name	and Addre	ss of Facilit Veber	<sup>ty</sup> Fun∈	eral_H	omes	P.A.	•	1	1122
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Division of V pital or Attending Ph purs after death. eral Director: After t filled in by the funeral	Certification:	- Curiordo	could not letermine	be		ury - Acric	mo, iam	, 50,500,					wn, State				
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) [ ]		Laron Locke MD.  31. Date filed (Month, Day, Y		stant Med		r's Signati	ure	_									
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	Physicia	n/	1. Decedent's Name (First, Middle Dan L. Jones	, Last)						Date of Deat Month	Day	Year	3. Time of Death 3:45 PM
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			SINAL HOSPITA  5. Social Security Number				BALT If Under 1 Year			Data of Birth		N/A	-lass Chata as Faurina
-	Funeral Director		529-46-9673 Usual Residence of Decedent	6. Sex 1 M 2 D F		st birthday) 72 Yrs.	Months Days			Date of Birth (Month, Day, ar 18,	<sup>Year)</sup> 1938	9. Birth Court	place (State or Foreign otry) tah
on	/land f show ad at	ţċ	10a. State 10b. County		10c. City	, Town or Lo							10d. Inside City Limits
Jones	ne Mary or 28a- notifie	Direc	Maryland Bal  10e. Street and Number	timore		Pike	sville			1	LOg Citizen	of What Cou	1 Yes 2 No
N	h with th ns 23a o nust be	Funeral Director	4418 Summer Gr				21	208			USA		
Dan Lewis 215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☒ Mar  3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.			Was Decedent of H f Yes, specify Cub I ☐ Yes 2 🂢 No	an, Mexic	can, Puerto Rica	Yes or No- an, etc.)		Race - Ameri Black, White, ecify: Wh	
21215-0	rithin 72 ho lene. r than "na the Medic	Completed		nt's Education est grade completed)  College (1-4 or 5	+)	(Give life. D	dent's Usual Occup kind of work done O NOT use retired, nistrato!	during me )	ost of working	Ŧ		of Business Ir on Univ	ersity
own as	d be filed w Vental Hyg arked othe atic event,	To Be	17. Father's Name (First, Middle, L Stan Jones			2.701112		Т	other's Name <i>(Fi</i>	irst, Middle, N			
puous re, Mary	id 2 shoul salth and l' n 27 is ma er trauma		19a. Informant's Name/Relations Daisy R. Jone	-			ng Address (Street Summer (						code) and 21208
Heuf kn Baltimore,	age 1 an ent of He nt: If iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (5				sition (Name of matory or other pla ematory	ce)	Date 05/15/			ion - City or T	own, State Maryland
Patient Baltin	permit. P Departm Importal any injur		21. Signature of Funeral Service L		regor		Name and Addre remation 99 Freder	ss of Fac	lety Of	Maryl			
کے ا			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death							arytan	Approximate Interval Between
	Prrysician/: Medical		Immediate Cause (Final disease or condition resulting in death)  a.   SEPSIS  Due to (or as a consequence of):										Onset and Death
	Examiner	ier	Sequentially list conditions, if any, leading to immediate  b. LEFT LOWER LOBE PNEUMONIA  Due to (or as a consequence of):										
	and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a	Due to (or as a consequence of):								
09	cate be executed physician and s the burial-transit	edical E	resulting in death) East	d.	Consequ	ence on.							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 4  Pregnant at 9  Unknown	2 🗌 Feta	Ideath 3	Ectopic pregnan Other (specify)	ісу			23d	I. Date of deliv	very Day Year
P.0.	that th ined by e detac	by Ph	Part II. Other significant condition										he cause of death?
rds,	equires een sig nould b	eted	POLYCYTHEN						MIA,				bably 4 Unknown
3eco	The law rate has bage 2 sl	Completed	CERVICAL AND LUMBAR STE	D LUMBAR ENOSIS	RA	DICUL	OPATH	(7)		24a. Was ar autops perforr 1  Yes	med?	prior to co death? 1 \sum Yes	opsy findings available ompletion of cause of
Ital	ician; Tertifica	Be (	25. Was case referred to medical examiner?  1  Yes 2 No	Hansitali			Tau	Place of D	eath (Check on				
of V	g Phys er this eral dir	e: To	27. Manner of Death	1 Inpatie 28a. Date of injur	y	28b. Time o	11 3 L DOA	rv at	Nursing Home 28d	5 Reside			y)
ion	tending leath. or: Afte the fun	Certificate:	1*☑Natural 5 ☐ Pendir 2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could	gation not be		injury		Yes 2					
Division of Vital Records, P.O.	tal or At rs after c al Direct ed in by	al Cert	4  Homicide determ				eet, factory, office		28f.	. Location (Sti City or Town		umber or Rura	l Route Number,
	n 24 hou n 24 hou le Funer	Medical	(Check 2 Medical E	Physician: To the best of Examiner: On the basis of examiner: To the l	amination	and/or inves	tigation, In my opin	ion, death	occurred at the	time, date an	d place, and	d due to the ca	ause(s) and manner stated.
	To the within common co	-	29b. Signature and title of certifier	AMIT B MBBS	HISE		29c. Licens		r 500			igned (Month,	
ı h			30. Name and address of person  AMIT BHISE					ORE	E MD	-212	15		
10	Stat Registra	e ir	31. Date filed (Month, Day, Year)	2010 A. Registra	r's Signat	re Sa	BALTIM						
DH	IMH 17 Rev 7/20	09		-1 7	0	RIGINA			·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Johnnie Lee Jones 9th 2010° 25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Civista Medical Center LaPlata Charles 6 1 Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min Jan. 23, Director 81 257-36-9380 Georgia 1929 Usual Residence of Decedent 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD 1 🔀 Yes 2 🗆 No Waldorf Charles 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 6501 Nutria Court 20603 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Parts Assembly Line General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aaron Brewer Ruby Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wolfe -Daughter 6501Nutria Court, Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 cemetery, crematory or other place) Cremation 3 □ RemovaLfrom State Conation 5 Other (Specify) Riversi<u>de Cemetery</u> 5-15-2010 Georgia 21. Sign ure of Fureral Service Licen Mathews Funeral Home 22. Name and Address of Facility 3206 Gillonville Road, Albany, GA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician or use as the burial Physician/Medical requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law cate has page 2 s autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Mannen of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu 1 Yes 2  $\square$  No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of of 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAY 18 2010

Robert T. Pace, MD 12070 Old Line Ctr. Suite 302, Waldorf, 32. Registra 's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

MD

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ ero u Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 🌠 M 2 🗆 F Months Days Hours Min. 2-4-194 SOUTH CAROLINA Director 219-50-0666 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3305 OAKFIELD AVE USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛣 No Specify. Specify: BLACK and Mental Hygiene. is marked other than "natural", Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12-LABORER LANDSCAPING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If Item 27 is marked c any injuy or other traumatic eve once. ည ELIJAH JAMES BETTY SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 OAKFIELD AVE. BALTIMORE, MARYLAND 21207 LAMES (WIFE) LOTS 20a. Method of Disposition 1 Burial 2 Gren 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🗀 **d**remation 3 🗆 Removal from State 4 Donat Other (Specify) KING MEMORIAL PARK 5-21-2010 BALTIMORE, MARYLAND uneral Service Licen eeJONATHAN HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 / a / 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line. Interval Between Imr ediate Cause (Final Onset and Death Physician/ di leaf e or condition resulting in death) Medical Due to (or as consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 No detached 9 Unknown Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has funeral director, page 2 autopsy perform Yes 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sr. Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident after death Director: / 1 🗌 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD 2903 5/18/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lewis Jackson Keller, 11:20 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death och Kauen Community LIVING 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 25, I Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Min. 1 **X** M 2 □ F Days 215-42-5734 Maryland Director 66 943 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore White Hall 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 932 Bernoudy Road 21161 TISA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, med Forces Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates.Vietnam Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Alternate Fuel Supply Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Lewis Jackson Keller Beverly Gavle Shock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaun P. Keller, son 3309 Partridge Drive Dover, PA20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 05/18/10 Baltimore, MD Signature of Funeral Service Licensee George MacNach 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Neoplasm Physician/ disease or condition lalignant Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Dav Year signed by the a Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? After this certificate 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 1 No Other 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes ☐ Accident 2 No Investigation within 24 hours after death To the Funeral Directors Suicide Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30 Name and address of person who completed cause of death (Item 23a) ven Wicks 21218 LUIVE

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (M

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh e904 6-3-10 vt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 2010 Month **Physician** May 7:55PM Herbert /Medical Knox 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Adventist Hospital Silver Montgomery Birthplace (State or Foreign Spring 8. Date of Birth (Month, Day, Year) 10/1/1916 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months Days Hours Min. Alabama Director 136-32-5151 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Mudical Examiner must be notified at Director Yes 2□No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 1110 Fidler Lane #520 Funeral 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 1937

1 Tyes 2 No. 954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian within 72 hours after 1 Yes 2 N If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛂 No Specify. 9 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 1963 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry المالية. \* Hygiene. \* r than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Police Officer Federal Government is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked other any Injury or other trailment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Barry Knox Alice McNair 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Knox/Wife 1110 Fidler Lane Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 6/8/2010 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artenoschenotic Condiovascular **Physician** COINS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) ed by the detached f 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2**1** No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 12 Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 001852

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Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

State Registrar 31. Date filed (Month, Day, Year) --- 32. Degistrar's Signal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RE MIS 4703 QUEENS YOUNG Re Hyattsville MID 2018

AY 18 2010 Queun S. par

Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Edward Kilkowski Jr. Joseph May 16 07:06 AM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3455 Old Crown Drive Pasadena Anne Arundel If Under 1 Year | if Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Hours Days Months 11√2 M 2 □ F 216-22-4857 Director 82 MD 20 1927 Sept Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. http://oritems.23a.or.28a-f show. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f show Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3455 Old Crown Court Drive 21122 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☑Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store Tailor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kilkowski, Sr. Joseph injury or other traumatic ပ Frances Jankiewicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Kilkowski 7902 Oak Point Court, Pasadena, MD 21122 permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other Date 17 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC.: 2010 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A, 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the diseas, or complications that paired the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on use in line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 🗀 Nursing Home 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina within 24 hours atter deaun.

To the Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of Permiler 29c. License number 29d. Date signed (Month, Day, Year) ox1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BUNDE MID 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

DHMH 17 Rev 1/2001

Certificate of Death

4b. City, Town, or Location of Death

BALTIMORE

2. Date of Death Month

5

MAY

KLISHCHENKO

Birthplace (State or Foreign Country)

UKRAINE

10d. Inside City Limits

1 Yes 2 No

21208

Year

2010

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

23d Date of delivery

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

15,2010

21215

ACANA ASNAN.

Year

4c. County of Death

N/A

UKRAINE

11,30AM

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

LEVINDALE HEBREW HOME

certificate has been funeral director, this

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 2 00 Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month. Dav. Year) D 68394 LEVINDALE

w. Belvedere Arence 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Balk were

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year PAULINE KLEIN 2:40 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death sinai Hospital Of Baltimore N/A Rallin ale city Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF Months 872871931 Director 059-26-3507 78 NY Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3504 MENLO DRIVE 21215 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Armed Forces? , or Black, White, et 1 Never Married 2 X Married δ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည STEINMETZ KAUFMAN BENJAMIN CELIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 NATHAN KLEIN/HUSBAND 3504 MENLO DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. PCHEVRIPSITALIAS Date 20c. Location - City or Town, State 0 Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State CHESED CEMETERY 5/17/2010 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License SOL LEVINSON & BROS. 22. Name and Address of Facility Scett) 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ NON SMALL CELL CARCINOMA disease or condition resulting in death) 3 YEARS Medical Due to (or as a consequence of) Examiner SUBENDOCAPDIAL INFARCTION DAYS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Due to (or as a consequence or). DAYS TLEUS COLONIC ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPONARY ARTERY DISEASE, LOWER EXTREMITY Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CELWLITIS, PERICARDITIS, OGILVIE SYNDROME 24a. Was an autopsy performed 2 No 2 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) (itle of cartifier 29b. Signatura 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MAY-17-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BHISE

31. Date filed (Month, Day, Year)

MBBS

SINAT

32. Regist s's Signature

Kiein

Pauline

HOSPITAL OF BACTIMORE, BACTIMORE MD-21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State	of Marylar		artment o		and Mental I	Hygiene Reg. N	2010	153	370
Physicia	n/	1. Decedent's Name (First, Middle,	*					2. Date of	Death		3. Time of	
Medic Examin	al	Betty Jane Li  4a. Facility Name (if not institution,	<del></del>	mber)		4b. City. Town	, or Location of	Month May	15	2010 c. County of Death	8:15	Рм
LAMINI		Ginger Cove H	lealth Ce	nter		Anna	apolis			Anne Ar	rundel	
Funeral Director		5. Social Security Number 221-14-9123	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs.	last birthday) 85 Yrs.	If Under 1 Ye Months Day		Min. July 9. Date of July 9.	Birth 25, 19	9. Birt 24 De l'a	nplace (State o (ntry) <b>ware</b>	r Foreign
how how	٦	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside Cit	ty Limits
Marylar 28a-f s	recto	Maryland Anne	Arundel		Annaj	polis					1 🗆 Yes	2 🔀 No
th the i 3a or 2 t be no	ral Di	10e. Street and Number				10f. Zip Cod	401		10g. C	itizen of What Co	untry?	
eath wi	Funeral Director	4000 Crescent D	12. Was Dec	edent Ever in U.	S. 13.			in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer		
<b>Daltimore, Imaryliand Z.I.Z.13-U030</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once.	þ	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 Yes If Yes, Given Year or D	orces? 2 <b>X</b> No ve ates.		1 Yes, specify Cl		Puerto Rican, etc.)		Black, White Specify: Whi		
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and be filed ental Hy ked oth c eveni	To Be	17. Father's Name (First, Middle, La Henry Allen	•					r's Name <i>(First, Mid</i> nah Greav	,	Surname)		
should and Mi is mar		19a. Informant's Name/Relationsh					et and Number	r or Rural Route Nur	nber, City o		Code)	
e, K and 2: Health tem 27 ther tr		Constance Linds 20a. Method of Disposition	ey, Daugh			addletre	e Road	San Anto		TX 78231	Town State	
Saltimore bearit. Page 1 ar Department of He mportant: If iten any injury or oth		1 Burial 2 Cremation 4 Donation 5 Other (S)	pecify)	State Met	cemetery, cre cro Cre	matory or other permatory	Inc. (	)5/17/10	Ba	ltimore,	Maryla	_
permi Depar Impor any in		21. Signature of Funeral Service Li	Sensee Thomas	s Grego	or   3	rematio 299 Fred	n Socie erick f	ty Of Ma Road Balt	rylan imore	d, Inc. Maryla	nd 2122	28
		23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that	caused the dear	th. Do not ent	er the mode of d	ying, such as c	cardiac or respirator	y arrest,		Approximate Interval Bets	e ween
Pnysician/- Medical		Immediate Cause (Final disease or condition resulting in death)	a. CO	or as a conseq	L V	hea	rT	fail v	re		4 YPA	rs
Examiner	<u>.</u>	Sequentially list conditions,	b. <i>D1</i>	late	d $Ca$	rdio	myop	athy			4 yea	175
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ne execucian and	dical Examiner	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):							
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at the ed by the detached		9 ☐ Unknown  Part II. Other significant condition			sulting in the	underlying cause	given in Part I.	23e. D	id tobacco	use contribute to	the cause of d	eath?
LIS, F puires then signed and be de-	ed by							1	☐ Yes 2	No 3□Pr	obably 4 🗌	Unknown
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ion ( eath. or: Afte the fun	Certificate:	1 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n	ation	nth, Day, Year)	injury		ork? ☐ Yes 2 ☐ I	No				
DIVISION ital or Attendir its after death. al Director: After led in by the fu	al Cert	4 Homicide determi	28e. Place	e of Injury - At he ing, etc. (Specif		reet, factory, offic	e		n (Street ar Town, State	nd Number or Rur e)	al Route Numb	er,
the Hosp iin 24 hou the Fune ipleted fil	Medical	(Check 2 Medical Ex	kaminer: On the ba	sis of examination	on and/or inves	stigation, in my op	inion, death occ	place, and due to the curred at the time, da and place, and due t	ite and plac	e, and due to the c	ause(s) and ma	nner stated.
To t To t		29b. Signature and title of certifier	Zenez	-MD			nse number 0 Z 95	7/	29d. Da	ate signed (Month	Day, Year)	
		30. Name and address of person w	who completed cau	se of death (Item 2 2 2 5		4		y, Cro	fton	MD	2/1/4	
Sta Registra		31. Date filed (Month, Day, Year)	32. F	Registrar's Signa	ature		1	, -				
DHMH 17 Rev 7/20	-	MAY 18	2010	lneva	B. A	farth					<u> </u>	

DHMH 17 Rev 7/2009

ORIGINAL

	1	For State Registrar		State of	Maryland		artment of <i>rtificate of</i>		d Mental Hy	giene Reg. No:		15371
		. Decedent's Name (First,	Middle, La	ist)					2. Date of De		Vees	3. Time of Death
Physician /Medical	ı	Leroy	V.	Lam					May	Day 17	Year 2010	07:20 AM
Examiner	4	a. Facility Name (If not inst	itution, gir	ve street and numb	ber)		4b. City, Town,	or Location of De	eath	4c.	County of Death	<del></del>
and .		Glen Burnie H	ealt	h & Rehal	o Cente	r		en Burni	е		Anne Ar	undel
Funeral	5	Social Security Number	6. 5		. Age (In yrs. la	**	If Under 1 Year Months Days		in. 8. Date of Bi	rth a <i>y</i> , <i>Y</i> ea <i>r)</i>	9. Birthp	place (State or Foreign
Director		217-24-2243		1 ☑ M 2 □ F	7	79 Yrs.			Jan. 3			MD
pug »	-	Jsual Residence of Decede  0a. State 10b. Co			10c City	Town or Lo	cation				1	0d. Inside City Limits
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with Dig			r Cox	1.30 ÷				21061		. og. om		,
leath	-	7981 Nollpar 1. Marital Status	K COI	12. Was Deced	ent Ever in U.S	. 13.	Was Decedent of	21061 Hispanic Origin?	(Specify Yes or No	0-	USA 14. Race - Americ	can Indian,
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exposure, out to multiply at To Be Completed by Funeral Director	:	1 Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Div		Armed Forc 1 ∑Yes 2 If Yes, Give Year or Dat	es? ! □ No		lfYes, specifyCu 1□Yes 2√∑No		' (Specify Yes or No Juerto Rican, etc.)		Black, White,	etc. ite
Maryland 21215-0036 of 2 should be filed within 72 hours aft the and Mental Hyglene. 27 Is marked other than "natural", or traumatic event, the Medical Event To Be Completed by F		15. Dec (Specify only)	edent's E	ducation ade completed)		16a. Dece (Give	dent's Usual Occi kind of work done DO NOT use retir	upation e during most of l	working	16b. Ki	nd of Business/In	dustry
laryland 2121 2 should be filed within and Mental Hyglene. Is marked other than aumatic event, the Marcol To Be Comp		Elementary/Secondary (0	-12)	College (1-4	lor 5+)		codial S			FL	Board of	Education
nd he filed tal Hyger of othe svent,		7. Father's Name (First, M.	ddle, Las	1)				18. Mother's N	Name (First, Middle	, Maiden	Surname)	
ylance ylance ylance wild be f arked of arked of artic eve		Scott	Lam					Mary	Kau	sman		
lary		19a. Informant's Name/Rela	ationship	(Type. Print)		19b. Maili	ng Address (Stree	et and Number or	Rural Route Numb	per, City o	r Town, State, Zip	Code)
Mand 2 and 2 sailth 27 I		Larry G. Si	nith	(brothe	r-in-law	) 82	07 Elkwo	od Court	, Pasade	na, N	4D 21122	
Baltimore, Mapermit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tran	2	20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema 4 ☐ Donation 5 ☐ Oth					sition (Name of matory or other pl matory I		ay <sup>Date</sup> 20 2010		imore, M	
Baltim permit. Pag Departmen Important: any Injury once.	1	21. Signature of Funeral Se	rvice £ite	nsee	1	2	2. Name and Add		Stallir oad, Pasa	ngs F	uneral H	lome, P.A.
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/Medical		disease or condition resulting in death)	-	a Due to (or	r as a conseque		0					ay ear
Examiner			- 1									•
2 2		Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	J	Due to (or	r as a conseque	ence of):						
executed the and the transit Examiner		Cause (Disease or injury that initiated events resulting in death) Last	1	C								
		resulting in death) Last		Due to (or	r as a conseque	ence of):						
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68 rtificat ng phy as th												
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O. Box ( ne death certif the attending hed for use as		23b. Was decedent pregna in the past 12 months? 1 ☐ Yes 2 ☐ No		1 Live bir	rth 2 🗌 Fetal int at time of de	death 3[	☐ Ectopic pregnar ☐ Other <i>(specify)</i>					*
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Is, P.O. Box ( es that the death certi igned by the attending be detached for use a by Physician/M		23b. Was decedent pregna in the past 12 months? 1 ☐ Yes 2 ☐ No	7	1 Live bir 4 Pregna 9 Unknov	rth 2 ☐ Fetal unt at time of de wn	death 3[ eath 5[	Other (specify)			tobacco u	Month	Day Year he cause of death?
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Putient Known as Eusene Louis Leimbert

			State of Maryland / Dep			ygien	e <sub>2 0 1 0</sub>	15372
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death		Reg. N	lo. 0 1 0	, , , , , ,
	Physicia Medic		Eugene Louis	Leimbac	2. Date of I		Year	3. Time of Death
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location			c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Und	der 24 Hrs. 8. Date of I	Birth	N/A 9. Bir	thplace (State or Foreign
	Director		212-03-1329	Months Days Hours	ms Min. (Month)	77192	0 0	MD MD
	Maryland 28a-f show otified at	tor	10a. State 10b. County 10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f	Director	MD Baltimore Parkvill					1 🗌 Yes 2 💢 No
	vith the 23a or st be		10e. Street and Number 2928 Willoughby Road	10f. Zip Code <b>21234</b>		"	S.A.	ountry?
	death vitems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic ( If Yes, specify Cuban, Mexic	Origin? (Specify Yes or N		14. Race - Ame	
336	2 should be filed within 72 hours after death w th and Mental Hygiene. 27 is marked other than "natural", or items: traumatic event, the Medical Examiner mu	d by	1 ☐ Never Married 2 🗶 Married 1 🗶 Yes 2 ☐ No	1 ☐ Yes 2 🕱 No Speci			Black, Whit Specify:	e, etc. White
5-0	"natur	plete	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during m	nost of working	16b.	Kind of Business	
21215-0036	ithin 73 ene. • than the Me	Completed	Flementary/Seconday (0-12) College (1-4 or 5+) life. D	ities Engine	3	Ai	ircraft	
ر کار 102	filed w al Hygi 1 other vent, 1	Be	17. Father's Name (First, Middle, Last)		other's Name (First, Midd			
Maryland	uld be Menta narked natic e	욘	William August Leimb	ach Anı	ne		0	'Connor
Mar	2 shouth and the and 27 is number traum			ng Address (Street and Num Norrisville				*
iore, N	of Hea of Hea fitem		20a. Method of Disposition 20b. Place of Dispo		Date		Location - City or	
E	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any fujury or other traumatic event, the Medical Examiner must be notified at ance.		4 Donation 5 Other (Specify) Moreland	Memorial	05/17/2010	Bal	timore,	Maryland
Balti	permit Depar Impor any in once.			2. Name and Address of Fac 5305 Harford				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such a	as cardiac or respiratory	arrest,		Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)					Onset and Death
manufal .	Examiner		EMPERIO CIPICA VI	COUR D				
1.	p #	Examiner	f any, leading to immediate a subset of the course. Enter Underlying Due to (or as a consequence of):	>0.00				
128	be executed sician and burial-transit	Exan	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):					
09	ate be e	dical	d					
	rtificat ing ph e as th	/Mec	IF FEMALE:					
Box 687	ath certifica attending p	cian,	23b. Was decedent pregnant in the past 12 months?  1   Very 2   New 3   Very 3   Ver	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
O. B	hat the death ed by the atte detached for	hysi	1  Yes 2  No 4  Pregnant at time of death 5 L 9  Unknown	(0,000.1)				
, P.O.	w requires that s been signed t should be det	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the Clost Ridium difficile Colifs	inderlying cause given in Pa				the cause of death?
ords	requir been s should	letec	Croynelland sellinell (Oll)		1 L			robably 4 Unknown topsy findings available
3ec	he law te has age 2:	фщо			aut per	opsy formed?	prior to death?	completion of cause of
tal	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	26. Place of De	Death (Check only one)	5 Z [yz] N	ioj i i res	5 2 Lg/F INO
Ţ	Physic this c	유	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of injury 28b. Time of		Nursing Home 5 Re			ify)
o uc	nding ath. r: After e funer	icate	1 Natural 5 Pending (Month, Day, Year) injury	28c. Injury at work?  M 1 1 Yes 2	28d. Describe	how inju	ry occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office		(Street ar		ral Route Number,
۵	ospital hours uneral l	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date an	nd place, and due to the o	ause(s) a	nd manner as sta	ited.
	the Hithin 24 the Formplets		(Check 2 Medical Examiner: On the basis of examination and/or investionly one). 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, da	late and place, and due to	the cause	(s) and manner as	stated.
	To vit		Ily For MD	000696	699	Me	ate signed (Month	2010
-	10		30. Name and address of person who completed cause of death (Item 23a) (Type, F	of Balti	more		(	
	Stat Registra	_	31. Date filed (Month, Day, Year)  32. Registrar's Signature	2				-
DHM	TH 17 Rev 7/20		2000 -0 5010 /01-10					

			1 - State Registrar	otato or maryiar		rtificate of I		Wentairi	Reg. No.		
	Dhuaisi	/	1. Decedent's Name (First, Middle, L	.ast)				2. Date of D			3. Time of Death
	Physicia Media		Robert Lacke	-				May	16, Day 2	OTO	10:00 PM
	Examir	er	4a. Facility Name (if not institution, gi				r Location of Dea	th	4c. Count	y of Death	
-	<i>/</i>		Stella Maris 5. Social Security Number 6.				onium			ltimo	re
	Funeral Director			Sex	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth (ay, Year) (1945)	9. Birthp Count Mar	olace (State or Foreign try) <b>1 and</b>
	ind show at	៦	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					0d. Inside City Limits
	//aryla 8a-f tiffied	ect	MD Balti	more	Ba1ti	more				"	1  Yes 2 <b>XX</b> No
	the h	<u></u>	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	
	s 23s	Funeral Director	1503 Barrett	Rd.			21207		_	S.A.	•
	death item	Ē	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	14. Rac	ce - America	an Indian,
X 16, 2010 10:00 p.m. Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes <b>XX</b> No If Yes, Give Year or Dates.		Yes XXNo		to rican, etc.)		ck, White, e	
P.m.	72 ho "nat	Completed	15. Decedent's (Specify only highest of		(Give	dent's Usual Occup kind of work done o	ation during most of wo	rkina	16b. Kind of E	usiness Ind	ustry
P 7	thin 7	Son	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired) <b>broider</b>			01-1	T	·
00 d 2	led wi Hygid other ent, t	Be (	17. Father's Name (First, Middle, Last	)	EIII	proider	10 Makharia Na	man (First & Sidal)			ndustry
10:00 /land 2	12 should be filed alth and Mental Hy 27 is marked oth r traumatic event	To	Dudley Lacke					nces E	, Maiden Surnam	e)	
ary .	nd M nd M s mar		19a. Informant's Name/Relationship		10h Mailir	ng Address (Street a				21.1 7. 0	
2010 re, Ma	d 2 sładth a alth a 27 is		Teresa A Sheare	- PO abc		Barret			ore, M		
20 ore,	1 and of Hea f item		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date	20c. Location		
16, Itimo	permit. Page 1 Department of Important: If i any injury or c		1 ☐ Burial <b>② X</b> Cremation 3 d 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	emetery crem	Faiths y & Chap	5/	19/10		•	r, MD
alt	rmit.		21. Signature of Furer Service Lice		22	. Name and Addres					pel P.A.
MAY	9 9 E 8 9		techant	Janua							s, MD2111
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death	n. Do not ente	r the mode of dying	g, such as cardiad	or respiratory ar	rest,		Approximate
7	Physician/		Immediate Cause (Final disease or condition	RECTAL CANCE	R						Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ						_	
		Į.	Sequentially list conditions, if any, leading to immediate	b. ————							
	sit sit	ig	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	ence of):						
	ecute and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):						
0	tificate be executed ng physician and s as the burial-transit	Medical		· · · · · · · · · · · · · · · · · · ·	,						
8760	ficate g phy as the	ledi		<b>a</b> d							
တ	certii anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy				23d. Da	te of deliver	v
Box	death cer	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown		Ectopic pregnancy Other (specify)	у		Мо		Day Year
_	that the ned by the detache	Ph S	9 Unknown								
ROBERT LACKEY Vital Records, P.O.	s the	হ	Part II. Other significant conditions	contributing to death but not resu	alting in the ur	nderlying cause give	en in Part I.		obacco use contr	ibute to the	cause of death?
rds	requires been sign should be	sted						1 🗆	Yes 2 No	3 Proba	ably 4 🗌 Unknown
	law n nas b e 2 sk	Completed						24a. Was autor	osv r	orior to com	sy findings available upletion of cause of
ZER R	t The cate h							perfo		death?	: 🗆 No
RO ital	Physician; this certific ral director,	<b>ω</b> ∣	25. Was case referred to medical examiner? 1 □ Yes 2 🗶 No	Hospital:		Other	ce of Death (Chec	ck only one)			
4_	Phys	<u>۵</u>		1  lnpatient 2 E	R/Outpatient 28b. Time of		4		lence 6 X Othe		HOSPICE
u c	rding th. : After	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year)	injury	28c. Injury work? M 1 \(\sum \)	at Yes 2 □ No	28d. Describe h	ow injury occurre	:d	
isic	Atter	Į	3 Suicide 6 Could not be 4 Homicide determined	De Ope Plans of later All	ne, farm, stre		163 2 110	28f Location /S	treet and Numbe	r or Pumi P	Pourto Alumbor
Division			4 E Nomicide determined	building, etc. (Specify)		,,		City or Tow		r or nurar n	oute Number,
	lospit t hour uners	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	vsician: To the best of my knowle	dge, death o	ocured at the time,	date and place, a	nd due to the cau	use(s) and manne	r as stated.	
	the H hin 24 the F nplete	_	only one, o zz dertilynig ival	iner: On the basis of examination se Practioner: To the best of my	and/or investi knowledge, de	gation, in my opinion eath occurred at the	<ol> <li>death occurred a time, date and pla</li> </ol>	at the time, date a ce, and due to the	nd place, and due e cause(s) and ma	to the cause nner as state	e(s) and manner stated.
	<b>5 2</b> ₩. <b>2</b>	2	29b. Signature and little of contifier	11.10		29c. License	number		29d. Date signed	(Month, Da	ıy, Year)
			MAINUS	MN		K/49	792		5/17	2010	
3			30. Name and address of person who						, ,		
	State	3	JACKIE JONES, CR B1. Date filed (Month, Day, Year)	NP 2300 DULANE  32. Registra 's Signatu		EY RD.	TIMONIUM	I, MD 21	093		
7	Registra	1		2 2010 > Augus	A.	parker					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Lee 3 2010 1:18a. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Future Care Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2【XF Yrs. 216-12-3183 Director 08 03 90 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location worle r 28a-f show 1X Yes 2 □ No Baltimore Director NA 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code the Medical Examiner must be 21202 U.S.A. 1500 Lanhorne Ct. Apt 3A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? or iteme Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black 2 3 X Widowed 4 □ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 e filed within al Hygiane. other then " Elementary/Secondary (0-12) College (1-4or 5+) Food Service Sears 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental P 7 is marked of Racheal Johnson James Streams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21202 permit. Pages 1 and 2 s Dapartment of Health ar Important: If Item 27 is any Injury or other trau 1500 Lanhorne Ct. Apt 3A, Baltimore, Md Barbara Stocks-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) King Memorial Park 5/20/2010 Woodlawn, Md 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dise se or condition resulting in death) una cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause first linder, ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) ed by the a o 9☐ Unknown 9 Unknown مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records, 1 Yes 2 No 3 Probably 4 Unknown DemenTA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed? 1 Yes 2√ No of Vital or Attending Physician: : After this cartific s funerel director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending eftar deeth. I Director: Aff d in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours off.
To the Funerel DI
completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAY LT  $m m_0$ 31102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMUM MANY LAND north CHowles Strict 5901 m.D. Don HILOUN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	otate of Maryland	•	tificate of D		vieritai my	Glene Reg. No.	2010	15375
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath		3. Time of Death
	Medic	al	ROBERT EDWARD  4a. Facility Name (if not institution, give street	MILLINGS		4h Cita Taura an	Location of Death	MAY	P2		02:15 p M
	Examin	er	Holy Cross Hospital			Silver				County of Death  Ontgomer	·v
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days		8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		577-46-3309 Usual Residence of Decedent	74	Yrs.			Aug. I	, 193	35	DC
	and show dat	tor	10a. State 10b. County	10c. City,	, Town or Loc	ation				1	0d. Inside City Limits
	Mary 28a-f otifie	Director	MD Prince Geo	rges Hy	attsv						1 Yes 2X No
	ith the 23a or st be r	ral 🏻	10e. Street and Number 4209 Ogelthorpe St.	#103		10f. Zip Code 20781			-	izen of What Cour SA	ntry?
	eath w	Funeral	110	Was Department From in LLC	. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-		14. Race - Americ	an Indian,
9	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by I	1 Never Married 2 Married	Armed Forces?  1 2 Yes 2 1 953- If Yes, Give	1	Yes, specify Cubar  Yes 2 X No		Rican, etc.)		Black, White, Specify: 121	
21215-0036	atural cal Ex	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Year or Dates. 1956	5	ent's Usual Occupa				nd of Business In	ack
212	in 72 h e. nan "n	Jup	(Specify only highest grade c		(Give k	ind of work done do NOT use retired)	uring most of work	king	100. K	nd of Edsilless in	dustry
7	d with lygien ther th	Be Co	12th		Machi	nist				eau & En	graving
Maryland	ould be filed on the Montal Hyomarked oth	To B	17. Father's Name (First, Middle, Last) Henry Millings				18. Mother's Nam		Maiden S	Surname)	
ar <u>Z</u>	hould ind Me s mar umati		19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailin	g Address (Street a			er, City or	Town, State, Zip (	Code)
	and 2 should be of Health and Ment fitem 27 is marked rother traumatic erother traumatic		Anna Millings - Wif	e	4209	Oglethorp	oe St. #1	.03 Hya	ttsv	ille, MD	20781
Baltimore,	Page 1 al nent of H. ant: If iter ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem		ace of Dispos metery, crem	sition (Name of atory or other place	e)	Date	20c. Lo	cation - City or To	own, State
	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Mary		Veterans		-2010		ltenham,	MD
n D	permit. Departr Importa any inji		Victoria L	Merido	M	Name and Address arshall s 308 Suit1	Füneral Land Rd.	. Home o Suitla	of Ma ind.M	ryland D. 20746	
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca	ons that caused the death. use on each line.							Approximate Interval Between
- F	nysician/	i	Immediate Cause (Final disease or condition	Pneumonia						2	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque Coronary Art		icasca					
_		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque		ibeabe					
	cuted nd transit	Examiner	Cause (Disease or linjury that initiated events C. =								
_	icate be executed physician and is the burial-transi	alE	resulting in death) Last	Due to (or as a conseque	ence ot):						
00/	law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit	<b>ledical</b>	d								
α α ×	n certir r use a			f yes, outcome of pregnant		Ectopic pregnancy	y		2	23d. Date of delive	
ROX	e deat the at hed fo	ysici	1 Vec 2 No	4 ☐ Pregnant at time of de ☐ Unknown	eath 5	Other (specify)				Month	Day Year
7. Ö	that the	by Ph	Part II. Other significant conditions contrib	uting to death but not resul	lting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco us	se contribute to th	ne cause of death?
S.	quires t	ed b						1 🗆	Yes 2	□ No 3 □ Prol	oably 4 🔣 Unknown
COL	aw rec nas bee	ompleted						24a. Was auto	psy	prior to co	osy findings available mpletion of cause of
Ž	r: The icate h r, page	O	OF Mean and the madical					1 🛚 Yes	ormed? 2 \( \square\) No	death?	2 🔀 No
<u>Ita</u>	rsiciar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ital: 1 🔀 Inpatient 2 🗆 E	R/Outpatient	Otho	r:		danca 6	Other (Specify	1
0	ng Phy ter thii neral o		27. Manner of Death 1   Natural 5 □ Pending		28b. Time of injury	28c. Injury work?	at	28d. Describe h			/
001	ttendii death. tor: Ai the fu	Certificate:	2 Accident Investigation	On Dinas of Latinus Alabam		M 1□`	Yes 2 □ No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a		4 Homicide determined	<ol> <li>Place of Injury - At hom building, etc. (Specify)</li> </ol>	ne, iaim, sire	et, factory, office		City or Tov		l Number or Rural	Houte Number,
_	ospita   hours uneral ed fille	ledical	29a. Certifier 1 🔀 Certifying Physician (Check 2 Medical Examiner:								
	the H	Me	only one) 3 Certifying Nurse Pro	ctioner: To the best of my l	knowledge, d	eath occurred at the	time, date and pla	ce, and due to th	e cause(s)	and manner as sta	ated.
	►.≱ <b>占</b> 8		Dr ah	m.D.		_	16063		zau. Date	e signed (Month, I	/ n
			30. Name and address of person who compl		23a) (Type, Pr	rint)				1111	/ U
			Kanwaljig Nagi, M.I	1580 For			silver S	pring,	MD.	20901	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) NAY 18 201	32. Registrar's Signatu	re A. A	back					

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AMEND ITEM#20a-c, perfit, 6908, 10/5/2010, WS

State of Maryland / Department of Health and Mental Hygiene
Amend Item 1 per med cert 6909 11/3/10 dx For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $\stackrel{\mathsf{Month}}{\mathsf{MAY}}$ 12<sup>Day</sup> Physician/ Clarisse Leann McRoy 2010 2:00a М CLARISSE--McROY Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Aug. 20, Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 DM 2 🔀 F Months 266-29-6623 53 NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🛣 No MD Prince Georges Temple Hills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2277 Anvil Lane 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **2+** Elementary/Seconday (0-12) File Clerk FBI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Agnes Cleo Kennebrew Fletcher McRoy, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes Young - mother 1041 West Hillcrest Dr. Cocoa, FL. 20a. Method of Disposition
1 ☑ Burial 2 ☑ Fernation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State /25/2010 Sharpes, Fl. Rockledge, F Riverview Memorial 4 Donation 5 Other (Specify) Atlas Crematory  $\frac{2010}{}$ 21. Signature of Funeral Service Licenses Marshall's Funeral Home of Maryland, Inc. 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi ng, such as cardir c or resuratory arrest, Approximate shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ Medical resulting in death) Due **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-transi and that initiated events resulting in death) Last Due to (or as a con signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes 2 ☐ Unknown should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy this certificate has perform performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA May er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signatu 10 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Rea rar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 1554 Physician/ onstance Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Southern Maryland Hospital linton 8. Date of Birth (Month, Day, Yea Feb. 18, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F Days Hours Min Country) DC Director 579-44-9532 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature" any injury or other traumatic events. 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State **Funeral Director** 1 Tes 2 X No Temple Hills Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20748 2153 North Anvil Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No Specify: If Yes, Give **Black** 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 11th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Martha Wilson Connie Tinsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Temple Hills, MD. 20748 2153 NOrth Anvil Lane Michelle Mathis - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 5-17-2010 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Signature of Funeral Service Licensee Marshalldurss filmeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ cole disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Vicheter signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Dunknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner To the basis of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. 29a. Certifier (Check Cartifying Nurse Practioner To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 51 12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pelbreton Balfour SUXXUS 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month a Moore, Jr Edward Medical Stephen 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Washington Medica yrs. last birthday, 58 Yrs g. Birthplace (State or Foreign Maryland 8. Date of Birth **Funeral** 0ct. 4,1951 1 🕅 M 2 🗆 F Months 215-60-2084 Min Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location n' of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Glen Burnie Anne Arundel MD 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States Brighton Place 21061 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc <u>Ş</u> 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Recreation <u>Mechanic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ S. Kelly Edward Moore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 879 Brighton Place, Glen Burnie, MD. 21061 Marie Moore/ Wife Linda Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 5/ 17 /2010 Glen Burnie, Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME OF LANSHOWNE Signature of Funeral Service Licenses 719 Hammonds Ferry Road, Lansdowne, MD 21227 a 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final an Cev Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir as the burial-trans Dause (Disease or imjury attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No ed by the a g Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 2 No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident filled in by the Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completed Gertifying Nurse Practioners To the best of my knowledge, death occur d at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a (Type, Print) 100 , UKC 31. Date filed (Month, Day, Year)

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State

Registrar

NAY 18 201

Stephen

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Monroe 0515 AM Mary 2010 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE HOSPITAL AGNE 9. Birthplace (State or Foreign 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23,1942 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🕱 F Yrs. Maryland 214-40-3379 Director 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits i Hygiene. other than "natural", or items 23a or 28a-f show ient, it e Maziren Examitian mut be malified at 10a. State 10b. County 1 ☐ Yes 2 No Director Halethorpe Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21227 Funeral 1120 Elm Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk CSX Railroad d 2 should be filed with and Mental Hygie 7 is marked other ti 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Madeline Hufnagel Howard Belt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau
once. 6 Dovefield Road Maryland 21128 Perry Hall, Mr. James M. Monroe (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns. of Faith Cem. 5/20/2010 Baltimore, Maryland 4□Donation 5 Dother (Specify) Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA /Medical Due to (or as a consequence of): Examiner SBROSIS MONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 Z No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ Physician: The law requires pulmonari 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ■ No 24a. Was an performed? certificate 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely and manner stated. the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

121

State Registrar anes

ENUE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

2010

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 14 3. Time of Death Physician/ 2010 3:07 A. M Ruth W. Minotti May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Care Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 98 vrs 8. Date of Birth **Funeral** 1 M 2 X F Days November 29, 1911 **Vir**ginia **Director** 220-46-7653 Usual Residence of Decedent 28a-f sho 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director N/A Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Sherwood Avenue Apt. B 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ξ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Hospital 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard L. Wood Cora Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary B. Choma/ Daughter 2607 Crossgate Drive Wilmington Delaware 19808 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Most Holy Redeemer 1 X Burial 2 Cremation 3 Removal from State 5/17/10 Baltimore Maryland 4 Donation 5 Other (Specify) 5305 Harrford Road 21. Signature of Furteral Service Licenses 22. Name and Address of Facility **Leonard J. Ruck, Inc.** 21214 Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition neumani Medical resulting in death) Due to (or as a consequence of): **Examiner** rement Sequentially list conditions. Examine ri any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ca Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 menths?
1 Yes 2 No Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 100 ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated CP Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOU

Registrar's Signature

R125973

N. Charles St

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Hamilton Austin N		Cord, Sr. 1- For State	State o	of Maryla	and / E		rtment of tificate of	f Health an f Death	d Mei	ntal Hy		on No	201	0	15381
Physicia		Registrar 1. Decedent's Name (First	Middle,Last)							2	. Date of Dea		Vaar	3. <b>T</b> i	me of Death
Medical Examir		Hamilton Au				•					Month May 10, 2		Year		615 hrs
		4a. Facility Name (if not in 12230 Roundwood	_	street and nu	mber)			4b. City, Town, or Timonium	Location	of Death			County of I		
Funeral		Social Security Number	6. Sex		7. Age (li	n yrs. la:	st birthday)	If Under 1 Yea	r If Und	der 24Hrs.	8. Date of Bi	rth (MM/l	DD/YYYOC		e (State or Foreign
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or 28	Director	P. O. Box 4	72						131			•	USA	,	
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21215-0036 ald be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, I									First, Middle,		Surname)		
121 Id be f Aental narkee	B	John Hamilt  19a. Informant's Name/Re					T 19h Mailine	Address (Stre			Marty		ty or Town.	State, Zip (	Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	٩	H. Austin M			Son		4						-		, MD 2113
e, N. I and I and Health	1	20a. Method of Disposition		_				ition (Name of ce			Date		ocation - C		
Baltimore, permit. Pages I a Department of He Important: If ite		1 Burial 2 X Cre 4 Donation 5 Ot		_ Removal fr	om State	l	-	Cremato	ry	5/1	3/10	G.	len B	urnie	, MD
Salti armit. epartm inports jury o	- 1	21. Signature of Futura	rvic Licens	ee			22. N T. e	Name and Addres	s of Facil	ity 1 Home	of Di	ılan	ev Va	lley,	Inc.
	_	Michael 133a. Part I. Enter the dise	Flagie	cations that c	aused the	death	1.10	W. Pade	onia	Rd	Timon	lum.	MD 2	1093	proximate Interval
Physician Medical		failure. List only one	cause on eac	h line.								, -		Be	etween Onset and Death
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Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physompletely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregna past 12 months?	nt in the	1 Live t	oirth nant at tim	e of dea	H	tal death 3	Ector	oic pregnand	су		Month	Day	Year
Box e death c the atten	ysic	1 Yes 2 No 9	Unknown	g Unkn		01 000	5 O	her (Specify)							
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of Vital Records, ing Physician: The law requir After this certificate has been sureral director, page 2 should be	<u>٦</u>	1 ✓ Yes 2 N 27. Manner of Death	lo	28a. Date	of Injury	一一	28b. Time of		ıry at Wo	rk? 2	8d. Describe	how inju			-
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- C	~ ^-	Pamela E. South		Assistant				1 Penn Stree	ei, Baiti	more, ML	J Z 120 I				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ Francis Andrew Monks 13. 2010 11:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Stella Maris Baltimore Timonium Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
July 9, 1927 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Country)
Maryland Director 215-34-0844 82 Usual Residence of Decedent show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21009 402 Autumn Leaf Ct. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 9 <u>Maintenance Man</u> Community College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Edward Monks Sr. Helen Casandra Monks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 George E. Monks / Son 212 Kearney Drive, Joppa, MD 21085 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion U.M.C Cem. Donation 5 Other (Specify) 5-19-10 Bel Air, Maryland o of Fundral Service Limsee Skin t McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a sonsequence of: Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant : ☐ Unknown Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2X No After this certificate has 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) <u>6</u> Hospital: 1 🗌 Yes 2 **X** No 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 3 ☐ Suicide injury 5 Pending Investigation within 24 hours after deatl

To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Continue Number Practice of the best of my income and death occurred at the time, date and class and due to the requests and manner as atomic. (Check 29b. Signature and 29d. Date-signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 State

DHMH 17 Rev 7/2009

Registrar

FRANCIS MONKS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17, Physician/ 2010 9:10 A M MARZICOLA MARTIN ANTHONY Medical 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 62 Crystal Court 5. Social Security Number 7. Age (In yrs. last birthday) 81 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Aug. 9 Hours Min 1 🙀 M 2 🗆 F Maryland T928 **Director** 215-22-8045 Usual Residence of Decedent 10c. Cify, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene.

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If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced White Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Personnel Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rose Juliet Pifkowski Peter C. Marzicola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
62 Crystal Ct., Bel Air, Maryland 21014 19a. Informant's Name/Relationship (Type, Print) Alice M. Marzicola / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Bel Air, Maryland Air Memorial Gdn 5-17-10 Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Phiset and Death
OCE Immediate Cause (Final Pnysician/ 14 0 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): rany, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury ned by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No q Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be del þ 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the lirector, page 2 s death? 1 🗌 Yes 2 🗀 No after death.

Director: After this certification by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending М 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) thin 24 hours af the Funeral Di mpleted filled ir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of dertifier

State Registrar DHMH 17 Rev 7/2009 1

Ashkan Bahrani, M.D.

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month,

602 S. Atwood Rd., Suite 200, Bel Air, MD 21014

				_ For	Plea	ase Type or State o								<b>II Copie</b> 1ental Hy		45	ible.	153	381
5				1 - State Registrar					Ce	ertifica	ate of D	Death			Reg. N	-			/ () "
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518		Examin		4a. Facility Name (if	SECI LO	, give street and num CHRAWLN ALTIMORE	BLY	D:		4b. Ci		Location				c. County	of Death	<u> </u>	
29		Funeral Director		5. Social Security N 295–18–6	umber	6. Sex 1 D M 2 F	7. Age (Ir	n <i>yrs. l</i> a	st birthday Yrs.	If Un Month	der 1 Year	If Under Hours		8. Date of Bir (Month, Da Mar. 2	rth ay, Yea <i>r)</i>	23	9. Birthp Co <i>u</i> n <b>Ohi</b>	olace (State or Fo	reign
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<u>}</u>	with the	s 23a or ust be n	Funeral Director	10e. Street and Nur 2217 Low		len Road				10f.	Zip Code 2123	4			10g. C	Citizen of W	/hat Cour	try?	
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SIE	Baltimore,	age i and ent of He nt: If item y or othe		20a. Method of Disp 1 Burial 2		3 ☐ Removal from	State	20b. PI	lace of Disp emetery, cri ns Fui	position (Nematory o	lame of r other place Chap Bela	el j		Date 5, 2010		Location -	-	wn, State . <b>1 ,</b> Maryl	.and
万に	Baltin	Departm Departm Importar any injur once,		21. Signature of Fu			1.	and		22. Name	and Addres	s of Facili	ty	l and arkvil					
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V	760 cate be	physicies s the bur	ledica			d									_				
1	Division of Vital Records, P.O. Box 68760 all or Attending Physician. The law requires that the death certificate be	been signed by the attending physic should be detached for use as the b.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 I 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, out 1  Live 4  Preg 9  Unkr	Birth 2 [ nant at tin	☐ Fetal	death 3	☐ Ectop ☐ Other	ic pregnancy (specify)	у				23d. Date Mor	e of delive	ery Day Year	
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4	7o #	with To tl		29b. Signature and	1 -	makas		M	10	2	9c. License	number	000			ate signed		Day, Year)	
		6			ess of person	who completed caus	e of death	h (Item	23a) (Type,	Print)				ro. B	-	<u> </u>		MD-212	39
	П	Stat Registra	e	31. Date filed (Monta	h, Day Year)	AKASA 18 201032.R	erstrar's	Signatu	ure J.	par	Kal					·			. ,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:35 PM Morgan 2010 Annie B. 3 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Harford Gardens 8. Date of Birth NOV 26, 1920 Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. N. Carolina 1 □ M 3√□ F 89 216-52-0044 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wolfen Evariant count be notified at 11☑Yes 2 No Director n/a Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 USA 6105 Mover Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? □Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home housewife 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Addie Merritt John Morgan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6105 Moyer Ave. Balto, Md. 21206 Nettie Matthews (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State WoodLawn Cemetery May19,2010 Balto.Co,MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Sanature of Funeral Service Licensee 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Dementa Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05/14/2010 DOO 693 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waltham Woods Rd, Parkville Pron 8813 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DOROTHY ANNA JOHNSON MacKENZIE May 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Pikesville SUNRISE AT PIKESVILLE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 🗆 M 2 😾 F 96 Director 083-03-0959 New Jersey Dec Usual Residence of Decedent show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Pikesville 1 Yes 2X No Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 3800 Old Court Road within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Johnson Harry Anna Heubner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5731 Ridgedale Road, Baltimore, Maryland 21209 Ellen Jane MacKenzie (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns 5/22/10 Timonium, Maryland 21. Signatur of Fureral Service Downs e Martin D. Lawson MTCHELL WIEDEFELD FUNERAL HOME 6500 York Road, Baltimore, Mary HOME, INC. Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and I for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ned by the atter in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det ò Division of Vital Records, or Attending Physician: The law requires 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' וני 24 hours after death. in 24 hours after death. the Funeral Director. After this certificate יימושל in by the funeral director, ps 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital 1 Yes Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John R. Burton Pavillion DMAG 5505 Hopkins Bayview Cirle, Balto..MD 2122 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

		State of Maryland /	-	rtment of H		and M		- /	010	150	387
		Registrar  1. Decedent's Name (First, Middle, Last)	Ocit	meate or E	Catii		2. Date of De	Reg. No		3. Time of	Death
Physici		Angela Anna Novotny					Month	13.	2010		
Medi Exami		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of	f Death	May	T	ounty of Dea	6:10	A
LAdilli	iici	Gilchrist Center		Towson					altimo		
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last bir		If Under 1 Year	If Under 2		8. Date of Birt	th	9. Bi	rthplace (State o	r Foreign
Director		216-07-9554 <sup>1 □ M 2</sup> X F 92	Yrs.	Months Days	Hours	Min.	March 2	5, 19		ervland	
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses?									
Bal permit Depar Impor any in		I Stan & Spale	Eva	Name and Addres NS Funeral 00 Harford	Chape.	l & C Park	remation	Service	es - Pa	rkville	
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Sior Attend death ctor: /	l≌	2 Accident Investigation 3 Suicide 6 Could not be 4 Depricte determined 28e. Place of Injury - At home, fa	arm stree		tes Z 🗆 I		Rf Location (S	troot and N	lumbar or Di	ıral Route Numb	or.
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be		4 ☐ Homicide determined building, etc. (Specify)	arrii, caroo	,, ido.o.y, oo			City or Tow		ramber or ma	nar noate warns	SI,
Hospital 24 hours Funeral eted filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death oc	cured at the time,	date and p	lace, and	due to the cau	use(s) and i	nanner as st	ated.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	(Check 2 ☐ Medical Examiner: On the basis of examination and/only one) 3 ☐ Certifying Nurse Practioner: To the best of my known									iner stated.
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		The state of the s		D 5830	)3		1	May 13	, 2010		
10		30. Name and address of person who completed cause of death (Item 23a) (			, CL	<b></b>	N/ 3	-3 00	20.4		
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	Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month							Day	Year	3. Time of D	Death Рм
Marie .	/Medic	al	Patricia K. Ove		1		4b. City, Town, o	Location of D	05	11 20 4c. County o		3:40	P IVI
	Examin	er	4a. Facility Name (If not institution, g			Conto	, ,	wson	eatri	Balt		- Δ	
_	Funeral		Greater Baltin  5. Social Security Number 6.	Sex 7		. last birthday)	If Under 1 Year	If Under 24 F	rs. 8. Date of Bi	rth		_	Foreign
	Director		232-20-9296	1 □ M 💥 □ F	89	Yrs.	Months Days	Hours M	March	17 1921	Counti	ace (State or ry) WVA	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 C	ity, Town or Lo	ontion					d. Inside City	Limite
	laryla sho	ō	MD Baltim	ore		Timoniu						1 □Yes	
	the N 28a-i	Completed by Funeral Director	10e. Street and Number				10f, Zip Code			10g. Citizen of Wh	nat Countr	ry?	
	with 3a or		2300 Dulaney Valley Rd. 21093						USA		•		
	death		11. Marital Status	12. Was Deceder		J.S. 13.			(Specify Yes or No				
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Mydical Exastor out the positive and		1 Never Married 2 Married 1 Yes 2 N No If Yes, Give 9 Yes, Give Yes, Give Yes or Dates:			r in U.S.  13. Was Decedent of Hispanic Origin? (Specify Y. If Yes, specify Cuban, Mexican, Puerto Rican,  1 □Yes 2 ▼ No Specify:				Black, White, etc.  Specify: white			
2-00	72 hou natura		15. Decedent's Education 16a. Decedent's Usual Occupation 1 (Specify only highest grade completed) (Give kind of work done during most of working						16b. Kind of Bus	16b. Kind of Business/Industry			
2121	within jene. r than "	ldmo	Elementary/Secondary (0-12)	College (1-4a	r 5+)		DO NOT use retired tionist	d)	•	Oles Env	elop:	e Co.	
þ	al Hyg other	BeC	17. Father's Name (First, Middle, La.					18. Mother's I	Name (First, Middle	, Maiden Surname	_		
/lar	uld be Ments Irked Itic ev	10 E	Otto Essig					Ele	anor Ryar	1			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Middel Exacting on the traumatic event, the Middel Exacting on the could be confined at once.		19a. Informant's Name/Relationship Roger Overfield/							oer, City or Town, S Sparks, M			
ore,	Pages 1 a ment of Hea ant; If item ury or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from Sta	rea i		sition (Name of natory or other place	- , -	5/10	20c. Location - C	•		
<u>Hi</u>	urtmen urtmen ortant; injury		4 □ Donation 5 □ Other (Special Signature of Funds 1)	cify)	E		n Memori  . Name and Addre		ens	Finksbu	rg, N	MD	
Ba	permit. Departr Importa any Injt		Michael	Flagle					me of Dul	laney Val ım, MD 21	1ey,	Inc.	
			23a. Part I. Enter the disease, or co shock, or heart failure. List on	inplications that cause y one cause on each	ed the dea line.	th Do not ent	er the made of dvir	no such as can	diac or respiratory a	arrest		Approximate Interval Betw	een
1	Physician		Immediate Cause (Final disease or condition	- ACU	TE	HYPE	RCAPN	IC R	ESPIRATO	DRY FAIL	URE	Houk	25
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):	OUTIN	E D. II	AA (20 10 0)	DICTO	100	VEA	05.
	Ladillilei	늅	Sequentially list conditions,	b. Due to (or:	ONIC as a consec	ODS I	RUCIIV	FUL	INCOLONIC	יוש כוע ץ	36	76/1	
	nsit	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  ACUTE HYPERCAPNIC RESPIRATORY Foundation or resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  Due to (or as a consequence of):											
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Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	n 2 ☐ Fet	al death 3	Ectopic pregnanc	y		23d. Date Mon		-	ear
Cold (specify)  The transport of the specific													
۹.	s that ned b s deta	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?								ath?		
ğ	quires an sig uid be	ed by								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			nknown
000	e law re has bee je 2 sho	Completed							24a. Was	an 24b. W	ere autop	sy findings av	vailable
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ita	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner?						Death (Check only	one)			
× ×	hysic this call dire		1 ☐ Yes 2 No			ER/Outpatie		4 LI NUISII	g Home 5 ☐ Res	idence 6 □Othe	r (Specify	)	
n C	ling P	io i	27. Manner of Death  1. Natural 5 Pending		njury <i>Day, Year)</i>	28b. Time o Injury	Wor		28d. Describe	how injury occurre	t		
Sic	Attending ir death. ector: After by the funer	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 280 Place of	Injunt - At k	nama farm etr		Yes 2 □No	28f Location	(Street and Numbe	r or Purol	Pouta Numb	
Division of Vital Records,	al or A s after al Direct	Certification: To	4 ☐ Homicide determine	d building,	28e. Place of injury - At nome, farm, street, factory, office   28f. Locatio				City or To	on (Street and Number or Rural Route Number, Town, State)			
	To the Hospital or Attending Physician: The law Within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the within 2 To the I complet	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						10	05/12	120	10				
			Eugene	A. O.	bal	1	C1131	MC					
	Sta		31. Date filed (Month, Day, Year) <b>MAY 18 2010</b>	32. Regi	strar's Sign	part	1						
DU	Registr	001	MAI TO ZUIU	perme	p.	yeare							

State of Maryland / Department of Health and Mental Hygiene [ ] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Marie Margaret Paugh 2010 6:48 A M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City Johns Hopkins Bayview Medical Ctr. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours  $3^{(ar)}$  1941 Maryland Yrs Director 217**-3**8-3471 Usual Residence of Deceden items 23a or 28a-f shov ier must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director Dunda1k Baltimore Co. 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21222 2042 Larkhall Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or iten edical Examiner r 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Machine 1000. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) McDonalds Restaurant <u>Prep worker</u> 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Cullem George Schuler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 7918 St. Bridget Lane Dundalk, Maryland Mrs. Sharon Matheny (Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Holly Hill Mem. Gdns. 5/17/2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licenses 21. Signature of 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Maryland Dundalk. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrypmin Physician Cardiac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or ilnjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed | rector, page 2 should be det Completed by netrotatic breat cancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 Yes ၉ 1 Inpatient 2 X ER/Outpatient 3 IDOA After this c 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40850 12,2010 1 -0 lt May - MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKUN SQUAREDR. BALTIMORE MD 21237 9103 OTTAV. AND MID. VUNNE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 11 per spouse 6099. F1/3/10 lk Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPt1, II per dr., g903, dhb
Certificate of Death
Reg. No. 1 - State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 195 Physician/ 4:00 P M Tummer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Nursing Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min Country) Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Funeral Director Baltimore 1 🗆 Yes 2 🗙 No 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry onday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tinnie Davis Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 317 Elmora Avenue Raltimore, Mo 21 Barbara Spel 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematoly or other place) Method of Disposition - City or Town, State Burial 2 Cremation 3 Removal from State Marylano 4 Donation 5 Other (Specify) . Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Malnutrition Approximate Interval Between Immediate Cause (Final Chronic Peath Physician/ disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Gipleeding, Seizure disorder** 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hypertension has performed? Yes 2 1 No hours after death. Ineral Director: After this certificate 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 12-Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANG ALTIMORE AVF 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Richburg 12:15A 11 2010 4a. Facility Name (if not institution, give street and number)
Apt.128 May Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5107 Old Court Road Randallstown Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 1933 S. Carolina 1 ₹ M 2 □ F Months Hours 76 247-48-2872 Director Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Randallstown Baltimore Maryland 1 🗌 Yes 💥 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5107 Old Court Road Apt. 128 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced Completed the Me lical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 | h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Belf-Employed Truck Driver 8th grade permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Richburg, Sr. Carrie Lee Simmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 35 107 Old Court Rd 19a. Informant's Name/Relationship (Type, Print) Mary A. Richburg /wife 1 and 2 s of Health a 128Randallstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 5/17/10 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Signature of Funeral Service Licensee 240 Reisterstown Rd Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use copyribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed or Attending Physician: The 1 Yes 2 No 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident s 24 hours after death.

Funeral Director: After de fulleted filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 431615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave 15 31. Date filed (Month, Day State

Registrar

Box 68760

Division of Vital

10-03330 Wi

J-USSSU filliom Boardole	_	Please Type of Print in Black Indelible Ink. Ensure All Cop		gible.		
illiam Ragsdale		State of Maryland / Department of Health and Mental In For State  Certificate of Death	тудієпе	2010	5392	
		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Deat	eg. No.	3. Time of Death	
Physicia ledical Examir		William Ragsdale	Month April 30, 2	Day Year	1332 hrs	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of Dear	h	
		806 Abbott Court Baltimore				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H		th(MM/DD/YYYY) 9. Bi		
Director		218-44-2066   1 X M 2 F   64 Yrs.   Months   Days   Hours   M	in. 8-1-	-1945 Forei	gri puntry) VA	
		Usual Residence of Decedent				
, any	or	10a. State 10b. County 10c. City, Town or Location			10d, Inside City Limits	
Maryland 28a-f show 1 at once,		MD na Baltimore			1 X Yes 2 No	
Maryl 28a-1 d at o	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Cou	untry?	
th the Maryland 23a or 28a-f sho notified at once.		806 Abbott Court 21202		USA		
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (		- 14. Race - Ame White, etc.	rican Indian, Black,	
r deat or ite	필	1 Yes 2 X No		В	lack	
s afte ral", niner	Þ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind o	f work done	Specify: 16b. Kind of Business	Industry	
"natt	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	etired)	TOD. KING OF BUSINESS	na na	
136 hin 7, than edical	ompleted	12th na				
d with	S	17. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Middle, M	Maiden Surname)		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	John Ragsdale Audre	y Rose			
ould I	ပ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of	r Rural Route Num	nber, City or Town, Stat	e, Zip Code)	
MD d 2 sho lith and n 27 is		Vashawn Ragsdale-Son 5010 Denview Way				
s l an of Hea		20a, Method of Disposition  1 Name of cemetery, crematory or other place)  Mt Carmel Cem 5-	Date	20c. Location - City o	·	
Page Page nent o		4 Donation 5 Other Specify:		Balto, M	<u></u>	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Faireral Service Licensee 22. Name and Address of Facility 1 a		the second of th	MD 21202	
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			MD 21202 Approximate Interval	
Physician /Medical		failure. List only one cause on each line.	or respiratory arre	est, shock, of fleart	Between Onset and Death	
Examiner	П	Immediate Cause (Final disease or condition resulting in death)  a. Cirrhosis of liver  Due to (or as a consequence of):			Beatt	
b						
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						
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68760, certificate bunding physic se as the bur	23a, 27, per ME g903 5/19/10 TT    FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1					
Box e death c the atten	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown					
t the c		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
P.O. ires that to signed by	d b		1 Yes	2 ✓ No 3 Pro	bably 4 Unknown	
24a. Was an autopsy prior to death?    24a. Was an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24b. Were an autopsy prior to death?   24c. Was an autopsy					utopsy findings available completion of cause of	
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Vital Rec hysician: The this certificate I director, page	o Be	examiner?	sing Home 5	Residence 6 🗸 Othe	r: Scene	
27. Manner of Death (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurre						
Division tal or Attendi rs after death. al Director: A	ific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S or Town, S		ural Route Number, City	
Spital cours a	4 Homicide determined (Specify)					
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the						
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and du						
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ok a		30. Name and address of person who completed cause of death (Item 23a)				
1 8		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201			
St	ate				-	
Regist		MATIN /IIII / LINE D. MATIN				

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death t. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 14 DAVID LEON ROBINSON 2010 11:00p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Mar. 28 Country) West Virginia 1 🕅 M 2 🗆 F ĭ 932 Director 78 232-48-8027 Usual Residence of Deceden Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔯 No WV Montgomery Montcalm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PO Box 735 (Methodist Hill Road) 24737 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced th and Mental Hygiene.

If is marked other than "natural traumatic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Etna Robinson Mary Carpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Robinson - Wife 735, Montcalm, WV 24737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Denation 5 Other (Specify) Marcoalsland Cemetery 5-22-2010 Marco Island, Florida 22. Name and Address of Facility
CRAVENS-SHIRES FUNERAL HOME 21. Sign Mun COAL HERITAGE RD. 24701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Bilateral Pheumonia Physician/ week disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? ✓as 2 XNo 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes Other: 2 🔀 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred ✓ Natural 5 Pending 1 🗌 Yes 2 🔲 No ☐ Accident Investigation Suicide Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has 24 hours

filled in by the funeral director, Certificate: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05

10 CENTER DRIVE, BETHESDA, MD 20892

State Registrar

EBERLEIN 31. Date filed (Month, Day, Year) MAY 18 2010

Michae 32. Registrar's Signature ack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Manyland (Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day P Physician/ 2010 29 1750 М MARIO RIVERA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 92 OUTGOMERY CROSS HOSPITA VER RING If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Year 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 □ F HH 015-42-5491 Director Usual Residence of Decedent , or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 □ No 51 MONTGOMERY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9502 E LIGHT 09 UNK 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2☐ No Yes, Give Maryland 21215-0036 1 Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa one. Specify: WHITE 3 Divorced UNK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) UNK VIND UNK UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ NWW WNW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 FOREST RI MD CROSS HOSPITA 1500 GLEN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state Bignature of Funeral Services licenses Waste State Anatomy Board; 655 W. Baltimore Street Baltimore. Maryland 21201 Director Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATOR ABREST disease r condition resulting eath) Medical Due to (or as a consequence of) Examiner PAILL MINIAN. Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Alcoholic Liver Disease teen signed by the attending physician and should be detached for use as the burial-transit T e law equires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \_\_ Live Birth 2 \_\_ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, p. ge 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: T e law within 24 hours after death.

To the Funeral Director: After this certifica e has I autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖫 No 1 🔽 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examin only one) Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 2010

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

HAROLD

230

1500 FOREST GLEN RD

20910

of person who completed cause of death (Item 23a) (Type, Print)

ANSON

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Martin Lee Rosenthal 15° 4:15 P<sub>M</sub> 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 6, 1961 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Maryland 1 **X** M 2 □ F 48 **Director** 214-88-3850 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Parkville 1 ☐ Yes 2 XNo 10f. Zip Code 10g, Citizen of What Country? 8913 Waltham Wood Rd. Apt. B Funeral U.S.A. 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2x No Specify: "natural", 3 Widowed 4 Divorced Year or Dates is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Valley View Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .nnt. Page 1 and 2 shc.
-ant of Health and Me.
'tiem 27 is marked c.
't traumatic evr ည Paul Rosenthal, Jr. Mary L. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Rosenthal/Brother 2523 Glencoe Road, Baltimore, Maryland 21234 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May  $20^{\text{ate}}$ . cemeter, crematory or other place)
Evans Funera
Chapel Bel Air 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 2010 22. Name and Address of Facility
Evans Fureral Chapel & Cremation Services 21. Si eture of Funeral Service Licensee 8800 Harford Road, Parkville, MD a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or heart failure. List only one cause on each line. Interval Between Imm diate Cause (Final dise se or condition Onset and Death Ph sician/ arynara resulting in death) Medical Due to (or as a ownseque **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manuel of leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, is my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 116110 He unow, mo Name and address of person who completed cause of death (Item 23a) (Type, Print GEOFTE MOSIS OM, MOZUMO1

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

amend item 23a per doc g904 6-8-10 yt
Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND ITEM#5perfH, G903, 5/20/Z010, WS
State of Maryland / Department of Health and Mental Hygiene

Amend Items 23art1 per dr., g903rtificate of Death 1 - For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 13, May 5:30 P 2010 Donna M. Rowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carro11 Golden Living Nursing Home Westminster 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9 7. Age (In yrs. last birthday) **Funeral** 1 M XX Months Days Hours Min 219-56-2591 94 7,1915 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes XXVo Director MD Carro11 Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 3401 Jim Bowers Rd. 21157 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo 14. Race - American Indian, Black, White, etc. 1 □Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes XXNo Specify White ۵ Specify: 3€Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home it and 2 should be filed with Health and Mental Hygier tem 27 Is marked other them 27 is marked other them them the states of th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t be t Anna H. Hanson Frank D. Messenger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and : Department of Health Important: If Item 27 any injury or other tr. once. Jim Bowers Rd. Westminster, MD 21157 John Rowe / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) A**11** Faiths May 17,2010 Manchester, MD rematory & Chapel P.A.

22. Name and Address of Facilit Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Transient Ischemic Attach Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 1 month Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) I Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Tes 2 THO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director, After 5 Pending investigation 1 Aatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sel, 2010 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Wernurk CHACICO 15(450 5 tonal 31. Date filed (Month, Day, Year) Registr State 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day th 2010 **Physician** ROBBINS 4:45 PM TANIE M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE GENESIS RANDALLSTOWN CENTER RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛣 F 2 23 28 MD Director 216-24-2522 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Injury or other traumatic event, the Medical Examinar must be multified at 1 XYes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 items 23a U.S.A. 21229 by Funeral 15 North Athol Ave 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2√2 No Specify Black 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If Item 27 is marked other that any Injury or other traumants. Private Duty Nurse Hospital 12th\_grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Paten Smith ပ James Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1244 Valley Leaf Ct., Edgewood, Md 21040 <u> Maxine Bailey-Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, Md Crestlawn 5/19/2010 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1 Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Store End Kenal disease **Physician** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ arten 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ten 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 MNo Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: ၀ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

KHAWAJA, M.D.

(Pear) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0058965

BALTIMORE

1801

WENTWORTH

MD

2010

21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ MAY 16<sup>Day</sup> 2010 DORA ROBBINS 5:18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3420 ASSOCIATED WAY, APT. BALTIMORE OWINGS MILLS 416 If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country) GERMANY 1 🗆 M 2 і 🗙 F 4757 1927 557-02-5968 83 Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 1 ☐ Yes 2 🕅 No BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? Funeral 3420 ASSOCIATED WAY, APT. 416 21117 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I gene. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **HOMEMAKER** OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 LEWIN JETJA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH BERRY/SON 3004 LIGHTFOOT DRIVE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State HILLSIDE CEMETERY 5/17/2010 LOS ANGELES, CA 4 Donation 5 Other (Specify) eture of Funeral Service Licen 22. Name and Address of Facility LEVINSON & BROS., INCOAD, PIKESVILLE, MD SOL . 21208 8900 REISTERSTOWN ROAD, Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Myscordia disease or condition minutes Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a considence of): Hospital or Attending Physician: The law requires that the death certificate be executed Huperlin that initiated events Due or as a consequence of resulting in death) Last Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? febrilation 1 Yes 2 No 3 Probably 4 Unknown heart diseas 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 Division of Vital Records, 24 hours after death. Funeral Director; After within 24 hours after death

To the Funeral Director, A
completed filled in by the f

State Registrar DHMH 17 Rev 7/2009

20a Certifier

29b, Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Rd

Pikesville

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ 844 a Rodney Speidel 2010 Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death **Examiner** 4c. County of Death PG SOMERSE! AT 15UZLLO r 1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)
A pril 22, 9. Birthplace (State or Foreign Country)
D • C • Social Security Number 7. Age (In yrs. last birthday) **Funeral** 579-40-6460 1 🙀 M 2 🗆 F 82 192B **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland **Funeral Director** MD Hyattsville PG 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 Somerset Place 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married tx☐ Yes If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 x No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Gover Geodist 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Moser George Speidel 19a. Informant's Name/Relationship (Type, Print) Wife Priscilla Flowers-Speidel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 722 Somerset Pl. Hyattsville, MD 20783 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other prinal Journey 1 Burial 2 Cremation 3 Removal from State 5/19/10 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charisse N. Woods 2700 Edmondson Ave. Balto., MD 21. Signature of Funeral Service License of 1. Enter the drease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COASTRIC disease or condition resulting in death) COW MI DIET HE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown ate has been signed by the attendin page 2 should be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 N 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1' Natural 5 Pending work' 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nursa Practioner: To the best of my knowledge, draftconstant at the time, date and plans, and due to the naturals) and manner as state 29b. Signat title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11161 New Hampshire Ave. #201, Silver Spring, HD 26904 DR. Michael 31. Date filed (Month, Day, Year) 32, Registrer's Signature State Registrar Denne DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2010 10:45 AM May 6 Robert Franklin Strohminger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Mt. Airy 2505 Gillis Rd. 9. Birthplace (State or Foreign Country)
MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) Funeral Days Min. 1 X M 2 🗆 F 61 Hours (Month, Day, Year) 6/17/1948 213-48-7701 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes XX No Mt. Airy MD Carrol1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 21771 2505 Gillis Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Tax Auditor Enforcement State of MD 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Theresa Salchunas Melvin Stohminger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7301 Travertine Dr. Unit 407 Baltimore, MD 21209 19a. Informant's Name/Relationship (Type, Print) Melvin Strominger (brother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State S. Carroll Crematory 5/18/2010 Winfield, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Jurrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed I page 2 should be det Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 🗌 Yes 2 🗌 No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 2 🚺 မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Peath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death at the time. Jate and Jace and doe to the ra 29d. Date signed (Month, Day, Year) 29b. Signati . License number cause of death (Item 23a) (Type Print) Maleoly dune

State Registrar 31. Date filed (Month

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5401 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sparrow Sharon 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Seasons Hospice Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birui (Month, Day, Year, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Year) 1 🗆 M 2 🖾 F Days Hours 68 Yrs Director March 220-36-6228 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Maryland Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21224 USA 418 Oriole Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 XNo filed within 72 hours after 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Advertising 12 Ith and Mental Hygier 27 is marked other to traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Hornberger Willey Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Michele L. Tuttle - daughter 14 Sumac Road, Glen Bunrie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State May 15,2010 Metro Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stalligns Funeral Home, PA Signature of Funeral Service 3111 Mountain Rd., Pasadena, MD 21122 23a. P / 1. Enter the disease, or co./ lications that caused the stock, or heart failure. List only one cause on each line. eat. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Lung Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impury that initiated events Examine Due to (or as a consequence of): physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 movins?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 Unknown To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifics Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 1 Other (Specify) 2 11/No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🚂 🚅 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRay Opakel M.D 5/13/10 D0057465

Registrar DHMH 17 Rev 7/2009

5

State

Box 68760

P.0.

**Division of Vital** 

2835 Smith AV. 7 S-235, Balt more, MD. 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Resistrar's Signature

N.S. Rajapakse, M.D.

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** 42.AM 2010 10 /Medical Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c County of Death Examiner N/A 10 to DKI TOrc 8. Date of Birth (Month, Day, Year)
APR. 22,1932 MARYLAND Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrd. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2**火** F Director 215-28-6466 Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It a Madical Examination and Director MYes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 S. CHESTER STREET 21231 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTHONY ၉ KURSCH VERA NOVAGDA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a CHESTER STREET, BALTIMORE, MD 21231 STEVEN SERGI/ SON 239 S. other 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of F Important: If ite any injury or ot once. 1 ☐ Burial 2 【 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) CREMATORY 5/15/10 BAYVIEW BALTIMORE, MARYLAND Name and Address of Facility
JILLY & ZEILER INC. FUNERAL HO
901 EASTERN AVENUE, BALTO., MD. 21. Signature of Fu-FUNERAL HOME 1901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final TALLINE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WE , Wen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? þ Day Year 5 Other (specify) the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2X1 No icate has been sig , page 2 should b 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □Yes 1 ☐ Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 2 ER/Outpatient 3 □ DOA Certification: To 1 ☐ Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred ospital or Att.
24 hours after death.
aral Director; After Attending 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 28f. determined 4 Homicide within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) VY\_

State Registrar 31. Date filed (Month, Day, Year) 32. Regierar's Signature

30. Name and address of person who

ZERA MI

completed cause of death (Item 28a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ E1ma Stevens 2010 Cora 10:40AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Dunda1k 8553 Kavanagh Road 8. Date of Birth (Month, Day, Year) Feb. 21,1931 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, **Funeral** Months Hours 1 □ M 2 🗓 F Yrs. 79 Director 183-24-0621 Usual Residence of Decedent fshow Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Dundalk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 8553 Kavanagh Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Florence Durbin Soloman Leroy Dains 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8553 Kavanagh Road Dundalk, Maryland Becky Sue Burdynski(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: It any injury o 5/18/2010 Middle River, MD 4 Donation 5 Other (Specify) Hill Mem. Gdns 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pny<del>sicia</del>n/ erebrovaxular disease or condition Wics Medical resulting in death) Due to (or as a consequence of) Examiner Athero schoolic Caguantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death the be detached 9 Unknown 9 Unknown P.O. | ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 No Yes 2 24 hours after death.

Funeral Director: After this certifica eted filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 14 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 5  $\square$  Pending Vatural 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined the Hospital Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler To the Hosp within 24 hou To the Fune completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Knecki)unt May 14 2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Point

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May **Physician** 2010 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs 8. Date of Birth May 5, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Days New York 85 195-20-3365 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10h County items 23a or 28a-f show ner must be notified at 1 ☐ Yes XX No Adamstown Maryland Frederick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21710 3200 Baker Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2A No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 o, 1 ☐ Yes 2 XNo Specify Specify: þ 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Gernan John T. Stapleton ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 is I permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau 15 Bonnie Way Allendale, NJ 07401-1101 Paul J. Schmitt, Jr./Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 5/20/10 Hanover Twp. PA 4 Donation 5 Other (Specify) St. Mary's Cemetery 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Onknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4  $\square$  Nursing Home 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred completely filled in by the funeral 28b. Time of 27. Manner of Death Certification: 5 Pending investigation Director: After 14 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RFS-DOO 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Sravanya Gavini

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 18 2010

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ May Day Christine Schaede1 2010 Μ. 16 2:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8 Date of Birth 1 🗆 M 2 🕱 F 90 11-06-1919 Mary Tand **Director** 220-14-7539 Usual Residence of Decedent or 28a-f show be filed within 72 hours after death with the Maryland must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a Examiner must be Funeral 21236 211 Marion Avenue USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces 1 Never Married 2 Married Completed by Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important if item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calergo Assero Nunzia DePasquale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ellen Sletcher - Nièce 914 Leeswood Road Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cem. 05-20-2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disea shock, or heart failure se, or complication List only one cause that caused the death. Do not enter the *m*ode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ GASTROINTESTINAL HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 ☐ Yes 2 ₪ g ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown has been are 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate Yes 2 X No 2 🗌 No 1  $\square$  Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at I Director: After to in by the funeral 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 124 hours after one Funeral Direct determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 🟋 Gertflying Nurse Practioner To the best of my knowledge, death ornshed at the time, date and place, and disc 29b. Signature and title o 29d. Date signed (Month, Day, Year) berson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 B1. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 Registrar

16,

CHRISTINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 State of Maryland Department of Health and Mental Hygiene trar Certificate of Death Red. No. 1 - For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician SEYMOUR A.M DOROTHY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BRADDOCK HOTGHTZ FREDERICK VINDOBONA NURSING HOME MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

August 25, 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 99 219-30-6169 England Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Pedical Examinar must be a clifted 1 ☐ Yes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6351 Spring Ridge Parkway 21701 #113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify ģ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Fenne11 Gertrude ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Seymour - Son 6351 Spring Ridge Parkway, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 04/26/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee per DVR Paige Haight Herbert 6416 Sykesville Rd., Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced demontos **Physician** 7547HS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 221No certificate 2 🗆 No 1 □Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

Registrar

29b. Signature and M

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRAYEET BOLARUM NO 196 TJOHNE, FREDENCK, NO 21702

2. Registrar's Signature

29c. License number

DOOGULL3

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 103 201D 1 A-1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death dollston HO 7/40 IMORE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) Funeral Age (In yrs. last birthday) Days (Month, Day, 1 🔀 M 2 🗆 F Months Min. 73 213-32-8306 Director MD Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Owings Mills 10d. Inside City Limits Director MD Baltimore 1 🗌 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 Funeral USA 232 Cedarmere Circle 12. Was Decedent Ever in U.S. Armed Forces? 1.2 Yes 2 1 No. If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MTA Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechnic Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Clemus L. Smith, Mary Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Vicky Hill/Daufghter 232 Cedarmere Circle, Owing Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest V 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5/24/10 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun all Service I censes 22. Name and Address of Facilitari P. Close F. Svs, PA Belair Rd, Balt., MD 21206-5105 5126 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theno sclenotic Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Exami the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Prantioner: To the best of my Inciwiedge det the time 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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h	Division of Vital Records, P.O. Box 68760,	P.O. Box 68760,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed	at the death certificate be executed	E
	within 24 hours after death.		Ka
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		For State Registrar		•	Department of I Certificate of		Reg	. No. 201	0   540
Physic	ian	1. Decedent's Name (First, Middle, L	,				<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death
/Medi		Robert Loui		in		1	May	15, 2010	
Exami	ner	4a. Facility Name (If not institution, g	ive street and number)			or Location of Death		4c. County of Dea	
	_	390 Butler Roa  5. Social Security Number 6.		e (In yrs. last birt		erstown   If Under 24 Hrs.	8. Date of Birth	Baltin 9. Bir	nore rthplace (State or Forei ountry)
-uneral Director		216-30-5759	1 <b>X</b> M 2□F		Yrs. Months Days	Hours Min.	(Month, Day, Y	<sup>(ear)</sup> 1930	ountry) MD
		Usual Residence of Decedent						-,,,	
show	_	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limi
8a-f	Director		imore		Reisterstow	n			
Nor 2		10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
"natural", or items 23a or 28a-f show colcal Examinet must be notified at	Funeral	390 Butler Roa	12. Was Decedent E	Ever in II S		1136	cifu Ves or No-	USA 14. Race - Amo	erican Indian
item	Fun	11. Marital Status 1 ☐ Never Married 2 🔀 Married	Armed Forces?		13. Was Decedent of If Yes, specify Cub	ean, Mexican, Puerto I	Rican, etc.)	Black, Whit	
, "e	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:		Specify:	White
atura ical E	ted	15. Decedent's (Specify only highest g	Education	16a.	Decedent's Usual Occu	pation	16	b. Kind of Business	/industry
o	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	(Give kind of work done life. DO NOT use retire	during most of workii id)	ig		
- L	Completed		2		Electricia			Electr	ical
ital Hygi d other event,	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle, Ma	iden Surname)	
	2	Wilbert Seohnlei					s_Broadfo		
th and Mer 7 Is marke traumatic		19a. informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street	t and Number or Rura	l Route Number, (	City or Town, State,	Zip Code)
ther		Alice Seohnlein 20a. Method of Disposition	Wij		O Butler Ro			MD 21130 lc. Location - City or	
<u> </u>		1 ☐ Burial 2 🎇 Cremation 3	☐Removal from State	cemeter	y, crematory or other pla	ce)		ŕ	
= = =		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lic	• • • • • • • • • • • • • • • • • • • •	Carrol	1 Cremation 22. Name and Addr			Hampstead	
Impo any Ir		21. Signature of Authoral Service Lic	1		Eline Fune	·		Reisterst erstown, N	
	-	23a. Part 1. Enter the disease, or co	omplications that caused	the death. Do r					Approximate
ysician		shock, or heart failure. List one Immediate Cause (Final	ily one cause on each lir	ne.	Cell Car		_		Interval Between Onset and Death
/edical		disease or condition resulting in death)	a	a consequence			, , , , ,		1m2
aminer			h	·					
-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	of):				
and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с						
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attending physician for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of de	alivery
atte d for u	ciar	in the past 12 months?  1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)			Month	Day Year
e g	ysi	9 Unknown	9 🗆 Unknown						
3ch	by Pi	Part II. Other significant conditions		/	the underlying cause gi	ven in Part I.	23e. Did toba	cco use contribute t	to the cause of death?
ned by the a	d b	Alzheimors	Dem-	enfi-			1 ☐ Yes	2 € No 3 □ P	Probably 4 🗌 Unkno
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has been signed e 2 should be de	omplete						performe	LMA 1 IVA	e 21 INO
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nis certificate has been signed director, page 2 should be de	Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Ou	tpatient 3 □ DOA Ot		1 □Yes 2 [ (Check only one)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5409 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Marquerite Ann Sines</u> May 6:25 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, June 29 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □**X**F Months Days Hours Min Director 1942 278-38-5848 67 June\_ Ohio Usual Residence of Decedent or 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 335 Laburnum Road 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 should be filed with and Mental Hygier is marked other t Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ George Albert Dorenkott Dorothy Francis Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Sines / Husband 335 Laburnum Road, Edgewood, Maryland, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 🖟 uniyel 2 □ C/ from State 5/15/2010 | Fallston, Maryland hation 5 🛭 Highview Memorial Gdn. 21. Sign e of Fun 22. Name and Address of Facility McComas Funeral Home, P.A. Cokesbury Road, Abingdon, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 CERTIFICATION REPROVED BY MEDICAL EXAMINATE of delivery IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by has been sig 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? page certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year 28b. Time of Certificate: 28d. Describe how injury of gived patient full on a table 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending -11-2010 1 Yes 2 X No illed in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nambur or Flural Foute Number) (Street and Nambur or Flural Foute Number) (Street and Nambur or Flural Foute Number) determined nd Sloud 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 582 2-2010 completed ause of death (Item 28a) (Type, Print) nalo 31. Date filed (Month) , Day, gatrar's Signature State

DHMH 17 Rev 7/2009

Registrar

German	Vel	asco	Santiago	
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		1- For State Registrar	e or iviaryland r		tificate o				Reg. No.	ZUIU	0410
Physicia	an/	1. Decedent's Name (First, Middle,L						2. Date of De Month	ath Day	Year	3. Time of Death
Medical Exami	ner	German	Velasco S	anti				May 8, 20	010		0110 hrs
		4a. Facility Name (if not institution,					wn, or Location of	Death	1	. County of Deat	
		Baltimore Washington M				Glen B		out lo business		Anne Arundel	
Funeral				-	ist birthday)	If Under Months	1 Year If Under Days Hours	Min		(DD/YYYY) 9. Bir Foreig	gn
Director			XM 2 F	4	+3 Yrs			May 2	28, ]	1966 C	Puntry) Mexico
à		Usual Residence of Decedent  10a. State 10b. County	110	Oc City	Town or Local	ion					10d. Inside City Limits
ow ar											1 Yes 2 X No
yiand P-f sh	호	MD Anne A	Arundel	h	lanover	10f, Zip (	anda.		10a Citi	zen of What Cou	
or 28s	Director		1				076		rog. Citi.	Mexi.	-
ith th		7659 Ridge Road	12. Was Decedent E	or in H S	C 112 M/			n? ( Specify Yes or N			ican Indian, Black,
ath w	Funeral	1 Never Married 2 Marri	Armed Forces?					Puerto Rican, etc.)	0-	White, etc.	ican indian, black,
", or		3 Widowed 4 Divorce	1 Yes 2 X ed If Yes, Give Year	No	1 X	Yes 2	No specify:	Mexican		Specify:	White
ars af	ğ	15. Decedent's Education (Specify	or Dates:	eted)			ccupation (Give ki		16b. F	Kind of Business/	Industry
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	<del>-</del>	during m	ost of worki	ng life. DO NOT u	se retired)	į		
036 ithin ne.	힏	10				Cool	ζ			Restaur	ant
5-0 led w other	흥	17. Father's Name (First, Middle, La	st)				18.Mother's	Name (First, Middle,	Maiden	Surname)	
121 be fi ental l urked	a			1dan			<u> </u>		nton		Santiago
O 2' thould nd Ma is ma		19a. Informant's Name/Relationship	2,00	hew			(Street and Numb way Apt	er or Rural Route Nu		ity or Town, State oelt, MD	
MC and 2 s alth a alth a 27 raum		Mr. Mario Cesar A	Alfaro-Ruiz	_	Place of Dispos			Date GI		Location - City or	
of He If ite		1 Burial 2 Cremation	Removal from State		rematory or ot		or cernetery,	May 21,			
imci Pag		4 Donation 5 Other Spec		Pa	nteon			2010	_		ta, Mexico
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		ignature of Funeral Service Lic	ensee				ddress of Facility	1 2nd Ave	nue	SW Gle	n Burnie, MD
	$\dashv$	23a. Part I. Enter the disease, or con	nolications that caused th	- death				ral & Crem			Approximate Interval
Physician /Medical		failure. List only one cause on	each line.	e dodin.	Do not cittor t	no mode or	dynig, soor as car	and or respiratory ar	1031, 3110	on, or ricurt	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	A. Multiple Injuries  Due to (or as a consequence)	ience of	١٠						Death
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60, ate be	Med	IF FEMALE:	23c. If yes, outcome	of pregn	ancy				230	d. Date of deliver	,——
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Box 687 ne death certifica the attending pi	sici	1 Yes 2 No 9 Unkno	4 Pregnant at tir	ne of dea	ath 5 Ot	her (Specif	y)				
the de	Physician/	Part II. Other significant condition	aoundlown	ut not re	sulting in the u	inderlying c	ause given in Part	I 23e. Did t	obacco	use contribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  To Director: After this certificate has been signed by led in by the fameral director, page 2 should be detach	<u>a</u>									No 3 Prot	
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Re The ficate	Ş							1 ✓ Yes	2 N	0 1 🗸 Ye	es 2 No
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the state of t		4 Homicide  29a. Certifier 1 Certifying Phys	ician: To the best of my k			red at the ti	me, date and place		-		
the I- hin 2. the F	Medical		er:On the basis of examin								
S & S & S	Me	29b. Signature and title of certifier	and manner stated.			29c. I	icense number		29d. E	Date signed (Mor	nth, Day, Year)
		(and 4	allan	-			O.C.M.E.		May	8, 2010	
n		30. Name and address of person wh	o completed cause of dea	th (Item :	23a)						
~			tant Medical Exami			Street, Ba	altimore, MD 2	21201			
St	ate	31. Datti i de Manti Que Man	32 Registrad	Signato	racke						
Regist	rar	08501 - 0 -000	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Esther Oleva Smith 10:20 A M MA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death North Arundel Health & Rehabilitation Glen Burnie Anne Arundel Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. i. Social Security Numbe 165–32–8971 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days June 18, 1915 Pennsylvania **Director** Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. 10a, State 10b. County 10c. City, Town or Location must be notified at **Funeral Director** MD Anne Arundel Jessup 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1614 Colesbury Place 20794 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3X Widowed 4 □ Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be ( 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked off any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Stepp Jennie Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Norma Corrado / Daughter 1614 Colesbury Place Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD 21. Sign 4 of Fundal Service Licensee 22. Name and Address of Facility Singleton Funeral and Cremation M01220 Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition CONSESTIVE Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence on Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perforn death? After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work after death.

Director Aft 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) within 24 hours To the Funera Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans Kwy

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8 18 per FH G904 668 (2010 Wental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ 15<sup>ay</sup> 20 4 10 Sanders Elsworth 3:10P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millersville Anne Arundel 657 Wheatmill Court West | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birtuly 21,1914 Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Year) / (Month, Day, Year) / (Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 95 213-28-2260 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛛 No MD Anne Arundel Millersville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 657 Wheatmill Court West U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Proof & Bookeeper Bank Be 18 Mother's Name (First, Middle, Maiden Surname)
Edith
Eaith L. Stinchcomb 17. Father's Name (First, Middle, Last) ည William T. Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms Elaine W. Johnson/Daughter 657 Wheatmill Court West Millersville MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 21, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 2010 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service License Services PA 1 2nd Ave. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final allure Ph sician/ disease or condition resulting in death) 10 Medical Due to (or as a consequence of): Examiner ebrovasca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year Unknown has been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4, Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy deep performed? death? To the Funeral Director: After this certificate I completed filled in by the funeral director, page venous thumbosi 2 🗌 No 25. Was case referrer to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Name and address of pe pleted cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month \_ August E. Shobins City, Town, or Location of Death Eacility Name (If not institution, give street and number) Date of Birth (Month, Day, Age (In vrs. last birthday 9. Birthplace (State or Foreign 1**X**M 2□F 88 Hours Maryland 218-14-8292 Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 □Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Cool Meadow Court 21237 U.S. A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Grovery Store 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) August Shobins Eleanor Bayliss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Weininger/Nephew 6 Cool Meadow Court, Baltimore, MD 21237 20b. Place of Disposition (Name of Evansery, Francisco) May Date 19, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Forset Hill, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) Chapel-Bel Air 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 of Funeral Service Licenses 23/ Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im nedia e Cause (Final disease or condition resulting in death) ue to (or as a consequence of): Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 □ Yes 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f shov must be notified at

filed within 72 hours after

Pages 1 and 2 should be of Health and Mental

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Hygiene.

other traumatic event,

Important: If It any Injury or c

Funeral Director

Completed by

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attending physician and for use as the burial-tran signed by the a been si cate has l certificate

Examiner Physician/Medical þ Completed Be Jo After this

Certification: death. Funeral Director: rely filled in by the hours at er

Division or Vital Records, P.O.

To the Hospital or Attending within 24 h

State Registrar

Medical

1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To erritying Physician: 10 the best of my interest as the line, date and place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Injury

5 Pending

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		1- For State Registrar		Certific	ate of Death			Reg. No.		
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Medical Exami	iner	a delice baarie bpcrice					May 12	, 2010		0029 hrs
		4a. Facility Name (if not institution, give s				n, or Location of D	Death		. County of Death	
		41 Queen Anne Bridge Road				//arlboro			nice George	
Funeral		5. Social Security Number 6. Sex		n yrs. last bir	thday) If Under 1 Months	Year If Under 2 Days Hours	Adia		Cou	hplace (State or Foreig untry)
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imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with them of Health and Mental Hygiene.  Rant: If item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be post	-	Cecile Ogunsan/Mot			08 Highlan					
and 2		20a. Method of Disposition	· · · · I	20b. Place	of Disposition (Name		Date		Location - City or	
Ore toff : If i		1 X Burial 2 Cremation 3	Removal from State		ory or other place)			Ba	ltimore,	MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to		4 Donation 5 Other Specify: 23 Signature of Funeral Service Licenses		ric. Z.	ion Cemete		-21-10			
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If tien 27 is in injury or other traumatic		and an arrived Elicensee	2 v/ 1	- 01		dress of FacilityR				ral Hme.
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Box 68760, e death certificate be ex the attending physician ed for use as the burial.	Physician/Medi	23b. Was decedent pregnant in the	23c. If yes, outcome of 1 Live birth	τ pregnancy	Fetal death	3 Ectopic pr	egnancy	234	d. Date of delivery  Month  D	ay Year
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isic Atte er dez by tł	ical	2 Accident Investigation	May 12, 2010 28e, Place of Injury		3 hrs arm, street, factory, of	fice building, etc.	28f. Locatio	n (Street a	nd Number or Rur	al Route Number, City
Division of Vital Records, ital or attending Physician: The law requir is after death.  All Directors. After this certificate has been selled in by the funeral director, page 2 should I	ertification	3 Suicide 6 Could not be determined	(Specify) Single			-	or Tow	n. State)	lge Road, Uppe	
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	O	29a. Certifier			ath occurred at the tim	ne, date and place				
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To wit	Me	29b. Signature and title of certifier	d manner stated.		29c. Li	cense number		29d.	Date signed (Mor.	th, Day, Year)
		1/1//	1) Mi	$\mathcal{D}$	c	C.M.E.		May	12, 2010	
		30. Name and address of person who com	pleted cause of death	(Item 23a)						
21			sistant Medical E		111 Penn Str	eet, Baltimore	, MD 21201			
	tate	31. Date filed (Month, Day Year)	32. Redistrar's S	ignature 💅	B					
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 2 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayonth 13 Day 010 Year Kenneth Eugene Smith 8:11 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll 1909 Springhill Lane Hampstead If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, ) 1 X M 2 □ F Days Hours Country)
Maryland Director 82 216-22-8170 1927 Jun. Usual Residence of Decedent "natural", or items 23a or 28a-f show dieal Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XX No Carroll Maryland Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's United States Funeral 21074 1909 Spring Hill Lane America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes XX No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: White 3XXWidowed 4 □ Divorced Completed and Mental Hygiene.
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aumatic event, the M. die al. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Carpenter Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Smith Martha Lohmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Susan Hancock (Daughter 1512 Stone Road, Westminster, Maryland 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 17, cemetery, crematory or other place)
Evergreen Memorial
Gardens 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Finksburg, Maryland 21. Signature of Fun and Bern Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Smou 3296 Charmil Drive, Manchester, Maryland 21102 23a Shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final +nysician/ Due to (or s a consequence of): disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imput that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth 2 Live Birth 4 Pregnant at time of death 9 Unknown in the past 12 months? Month Year ned by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? certificate 1 ☐ Yes 2 🗹 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 Yes 2 **X** No Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🌠 Natural work? 5 Pending 2 No Investigation Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check only one Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rocha 4231 Northwoods Hampstead, Nd TRail 31. Date filed (Month, Day 32. Registrat's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16:42PM Smith Anthony 2010 Shawn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 44 Director 214-02-8341 03 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21215 <u>5100 Levindale Road</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1X Never Married 2 Married Yes . 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Elementary/Seconday (0-12) College (1-4 or 5+) Electric Company Meter Reader 3yrs 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Creola Missouri Eddie Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5100 Levindale Road, Baltimore, Md 21215 <u> Eddie Brooks-Father</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 5/18/2010 Arbutus, eture of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21215 Baltimore, 23a. Par . Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sp. ck, or heart failure. List only one cause on each line. Interval Retween Imm diate Cause (Final disease or condition Onset and Death Physician/ mour ue t (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events rcoidosis the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) signed by the a ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 🗆 Yes Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direc Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		_ For	Please	State of M				. Ensure A Health and N	•	•	gible.	10117
		1 - State Registrar				Cer	tificate of	Death		Reg. No.	JIU	10411
Physicia /Medic		1. Decedent's Name (F	5	nith					2. Date of Dea Month	Day 37	Year 2010	3. Time of Death 7:52 A M
Examin	er	4a. Facility Name (If no	Melno C	ve street and number)			beiling	r Location of Death		4c. Cour	nty of Death	
Funeral Director		5. Social Security Num えずるー  入って	er } 入 う 入	Sex 7. Ag	ge (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth	3 /93	Cour	place (State or Foreign ntry) Carolina
Maryland -f show	tor	Usual Residence of De 10a. State 10 MD	b. County			Town or Local					1	0d. Inside City Limits 1X Yes 2 No
h with the 23a or 28a	al Director	10e. Street and Number		rd Mill Ro	ad		10f. Zip Code 21208			10g. Citizen o	of What Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examination invalues redifficat at once.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐	2☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S			Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, cify: bla	etc.
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iled wi Hygier Iher th	Cor	12 17. Father's Name (Fir	et Middle Las	0		nur	se techn	ician  18. Mother's Nam	e (First Middle		ealthc	are
lid be f fental rked or iic eve	To Be	Forrest J		9					Manning	maiden odin	arrie)	
2 shou 2 shou is mai raumat		19a. Informant's Name						and Number or Ru				ŕ
1 and Health em 27		Joann Ca 20a. Method of Dispos		/niece	20b. Pl			Circle;	Pikesvi:		arylan on - City or To	
it. Pages rtment of rtant: If il		1 □ Burial 2 □ 0 4 ☑ Donation 5 I	remation 3 D		1		sition (Name of natory or other place	İ				
permi Depa Impoi any Ir once.		21. Signature of Funer ROT	al Service Lice	Wade Div	ector	S	Name and Addre tate Ana Saltimore	tomy Boar Marylan	d; 2655,1	W. Bal	timore	Street
Physician /Medical		23a. Part 1. Enter the shock, owneart for Immediate Cause (Fir disease or condition resulting in death)	allure. List only	nplications that cause y one cause on each li a Due to (or as	ne.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onsel and Death
Examiner up up up up up up up up up up up up up	Examiner	Sequentially list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju that initiated events	ions, diate ng Iry	b	a consequ	ence of):						
D Cis	cal	resulting in death) Las		Due to (or as	a consequ	ence of):						
Attending Physician: The law requires that the death certificate roteath. sctor: After this certificate has been signed by the attending physiby the funeral director, page 2 should be detached for use as the l	Physician/Medi	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1  Yes 2 N 9 Unknown	nths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 □	Ectopic pregnanc Other (specify)	Sy.			Date of deliv Month	ery Day Year
quires that the de n signed by the a lid be detached f	by	Part II. Other significa	nt conditions	contributing to death b	out not resu	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did to			he cause of death?
The law requirate has been signage 2 should l	Completed		An	min					24a. Was autop perfor 1 □ Yes	rmed	lb. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
Iclan: Sertifica ector, p	Be C	25. Was case referred examiner?	to medical	11				26. Place of Dear			1 🗆 163	2 🗆 110
Physic r this caral dire	: To	1 ☐ Yes 2 ☑ No 27. Manne of Death		Hospital: 1 ☐ Inpati 28a. Date of Inji		ER/Outpatier 28b. Time of	t 3 □ DOA Oth	4 Nursing H	ome 5 Resid			fy)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	Pending investigation  Gould not lot determine	(Month, Da	ay, Year)	Injury	Wor	k? ]Yes 2 □No				al Route Number,
spital or and and a spital or		4 ☐ Homicide  29a. Certifier 14	Certifying P	hysician: To the best	of my knov	vledge, death	n occurred at the ti	ime, date and place	City or Tow	vn, State) cause(s) and	d manner as	stated.
the Ho thin 24 h	Medical	(Check only 2[ one) 29b. Signature and title	J Medical Exa	and manner st	of examinat	ion and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and plac	ce, and due t	o the cause(s)
<b>7</b> × 5 %	_	Sob. Oignature and title		->	MA		29c. Licens	2756	g	29d. Date sig	111/0	Day, rear/
7		30. Name and address	of person who	completed cause of	death (Item	23a) (Type,	Print)	(38 G	Teene	Tue	2 So	121208
Sta		31. Date filed (Month)	AYTS	2010 32. Rigist	rar's Signat	ure	barker	7		,		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 16 Physician/ 2010 Smith, Sr. Walter 4:04 a Raymond Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth All gnth, Pag Year 1924 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 D F 218-18-0093 85 MaryTand Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21093 2300 Dulaney Valley Road 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 43-46 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BGE/Utility Electrician and Mental Hygien is marked other th 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever ဂ္ Bellerson Marie Smith John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21074 18308 Upper Beckleysville Rd., Hampstead, MD 19a. Informant's Name/Relationship (Type, Print) Raymond W. Smith-son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/19/10 Baltimore, MD Most Holy Redeemer 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** 1 Yes 2 X No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury Accident 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Direct completed filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month. Day. Year. of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULAENY VALLEY RD. TIMONIUM, MD 21093 State Registrar DHMH 17 Rev 7/2009

a.m.

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SMITH

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 14 3. Time of Death Physician/ 2010 May\_ Sheila Marie Shannon 4:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3450 Halcyon Road Baltimore Stevenson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 111 V 17 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 58 Director 219-58-1099 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 😾 No Maryland Baltimore Stevenson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 3450 Halcyon Road Was Deceue... Armed Forces? Yes 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: 3 Widowed 4 Divorced Specify. White and Mental Hygiene.
is marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Accountant <u>Global Pavments</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve once. ည Andrew J. Shannon Margaret M. Behan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 Rose S. 8820 Walther Blvd Apt. 4108 McCauley (Aunt) <u>Parkville. Marvland</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 5/17/2010 Parkville Maryland 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Mil 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Ph sician/ Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 \(\sumseteq\) Yes 2 \(\mathbb{N}\) No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 K Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No page 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) ဂ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide within 24 hours after de:

To the Funeral Directol
completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State To the Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie License numbe 29d. Date signed (Month, Day, Year) Charles May 14 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bivd Charles Padgettino 5601 Loch Raven Bivd Raltimore, Ow Lock Kaven State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 John Henry Taylor Jr. 3:45 Mav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 626 Ingleside Avenue Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 92 Months Hours Feb 1, Year 1918 Mary Tand Director 212-16-9294 Usual Residence of Decedent 3a or 28a-f show be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 626 Ingleside Avenue 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Worker Roofing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John H. Taylor Hannah Jester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7375 Dale Avenue Easton, Maryland 21601 JoAnn R. Lambert, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/17/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final FAILURE Physician/ HEART ONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of Examiner DISEASE Secreptially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant :
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No ed by the a detached f g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No 10 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) ss of persor completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) Registr s Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 14, Physician/ Year 2010 4:00 Mary Orene Dickinson Todd Αм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign (Month, Day Months Days Hours Min 1 □ M 2 🔽 F Virginia Director June 229-56-2386 1915 94 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 Providence Road 21209 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard S. Dickinson Julia Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James T. Todd (Son) 1309 Providence Road, Towson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Wilchern esset) Bapterse 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ion 5 🗆 Other (Specify Church Cemetery May 19,2010|Spotsylvania, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Johnson Funeral Home, Inc. 31440 Constitution Hwy., Locust Grove, VA 22508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Cancer MERISHAC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe within 24 hours after death.

To the Funeral Director, After this certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONSON MO

State Registrar 31. Date filed (Month, Day, Year)



HARVES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Lee Teal, Sr. Month 2:25 PΜ May 2010 Medical a. Facility Name (if not institution, give street and number)
Upper Ches apeake Medical Center Examiner 4b. City, Town, or Location of Death 4c. County of Death Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 214-30-3715 1 X M 2 □ F Days Hours Min. Feb. 1, 1934 76 Maryland Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Harford Joppa 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 578 Trimble Road TR5 21085 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Self-Employed and Mental Hygiene. is marked other tha Stone Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herbert Gilmore Teal Esther Dorothy Fuller permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Teal/ Wife 12208 Philadelphia Rd. Kingsville, MD 21087 Date 20, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Moreland Park 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Memorial Parkville, Maryland Donation 5 Other (Specify) Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility | Chapel & Cremation Services | 8800 Harford Rd. Parkville, MD 21234 NOVI 2 a. P. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. m diate Cause (Final see se or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate Examiner Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No that the death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ The law requires Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes Vital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA hours after death. Ineral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Division work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number
D 0067027 2010 igur Chesapana Dr. Bel Ain MP 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day

fountain, mp

10-03565
George Carr Toe

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible?

·	- 1		ate of Death	Reg. No.	
Physicia	ın/	1. Decedent's Name (First, Middle,Lest)		2. Date of Death	3. Time of Death
Medical Examin	ner	DECOLUE LA LOCALIDE		May 8, 2010	ear 2255 hrs
		4s. Facility Name (thirt institution, give street and number) 900 Blk. of North Hitt Road	4b. City, Town, or Location of Deat Baltimore	4c, Count	y of Death
Funeral	-	5. Social Security Number 6. Sex 7. Age (in yrs. last bir		8 Date of Birth/MANDONN	Y) A Y) 9. Binhplace (State.or Foreign
Director		213-59-6587 1× 20= 30	Yrs, Months Days Hours Min		Country)
	ŀ	Usual Residence of Decedent	118.	Jan. 15, 1981	I Liheria.
Şu .		10a. Stata 10b. County 10c. City, Town	or Location		10d. Inside City Limits
and show	5	IMa NA Ba	Itimore-		1 \ Yes 2 \ No
kery l	3	10c. Street and Number	10f. Zip Code	10g. Citizen of V	What Country?
-dealt with the Maryland or items 23.4 or 28mf thow must let notified at ante.	Funeral Director	14000 Ridge croft Rd.	21206		SA
h wit	619	11. Marital Status 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Ra	ce - American Indian, Black,
and a series		1 Yes 2 No		recan, etc.) wh	Ite, etc.
Tath Talen	ক	3 Widowed 4 Divorced if Yes, Give Year 7 To Detect 15, Decedent's Education (Specify only highest grade completed) 166.	1 Yes 2 No specify:	Specify	Black
5-0036 ted within 72 hours after Hygoria and antireally, to other than "natureally, to the bladfan Examiner.	ompleted	Elamentary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use reti	work dona 165. Kind of Fired)	Rusiness/Industry
Harrie Harris	힐	12. 0	elf-employed	1/	
State of the state	하	17. Father's Name (First, Middle, Last)		(First, Middle, Maidan Suman	2 Improvement
D 21215-0036 should be filed within 7 and Messial Hygiene. In the Messial Hygiene. The cereor, the Messian and cereor, the Messian	å	Anthony Top.	Cont	Fort Gou	
D 25	٩	19a. Informant's Name/Regationship (Type, Print) (Father) 19	b. Mailing Address (Street and Number or t	Rural Roule Number, City or To	wn, State, Zip Code)
<b>2</b> 5 5 5 5	-	Mr. Anthony De 16	343 Greenway	Ave Phil	a.Pa. 19142
OFE, M es I and 2 of Health If Item 2 in er traum			of Disposition (Name of cemetery, tory or other place)		n - City by Town, State
Baltimore, permit. Pages I su Depurment of Bra Important: If Ite Important: Ite I	ļ		y Cemetery 6/5		775-Md 1
Baltimo Permit. Page Depurment Important: Injury or od		21, Signature of Funeral Service Licensee	22 Name and Address of Facility	Emperal II-	a D a
Physician	+	23a. Part, Enter/pre disease/or complications that caused the death. Do not	12222 W. North A.	e Batharak	121716
aviedical	1	relique, Listronty one cause on each line.	to the upper of child' \$000 95 C940190 0	ir respiratory amest, shock, or h	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  B. Gunshot wounds of head  Due to (or as a consequence of):			Death
62	1	Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of); causa. Enter Underlying Cause			
-	Εl	(Disease or injury that initiated events resulting in death) Last  Oue to (or as a consequence of):			
		d.			
68760, certificate he externied ording physicien and sea to the bound - transi	cian/Medical	UNPENDED AMENDED #203-C DEFT	FH,G903,5/26/2010,WS		
68760, certificate be iding physici	žŀ.	TEMALE: 230, If yes, outcome of pregnancy	11,0000,07,207,2010,WB	23d. Date	of delivery
certificate reduces physical tests to the	ig.	b. Was decedent pregnant in the past 12 months?	Fatel deeth 3 Ectopic pregns		Day Yaar
		past 12 months?  4 Pregnant at time of death 9 Unknown	Dither (Specify)		
P.O. BOX	2	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use con	tribula to the cause of death?
	Ď.	/			3 Probably 4 Unknown
or requirements about	Completed			24a. Was an 124b.	. Were autopsy findings available
Pe law	E			autopay perform <u>ed</u> ?	prior to completion of cause of death?
tal Rec		25. Was case referred to medical	AC Dinas of the literature		1 Yes 2 No
	8	examiner? Hospitali C	26.Place of Desth (Check utpatient 3 DOA Other, Nursin	g Home 5 Residence 6	Charl Bass
n of V dlkg Pbyu After tha funeral di	- 1-	27. Manner of Death 28a, Date of Injury 28b	Time of Injury   28c. Injury at Work?	284. Describe how injury occu	
Sion Arendis death.	흵	1 Netural 5 Pending May 8, 2010 Year) 0000	thrs 1 Yes 2 No	Subject shot	
ivision for Attend ther death Director: d in by the	<u>=</u>	2 Accident Investigation 3 Suicide 6 Could not be 28¢. Place of Injury - At home, fa	nm, street, factory, office building, atc.	28f, Location (Street and Num	ber or Rural Route Number, City
	ᇍ	4 1 Homicide determined (Specify) Local Street		or Town, State) Blk of North Hill Road,	
		29e, Certifier 1 Cartifying Physician: To the best of my knowledge, des	ith occurred at the time, date and place, and	due to the cause(s) and mann	er as stated,
Division  To the Hospital or Atte willin 24 hours after dea  To the Functal Direction  To the Pointed Direction  To the Attendance of the	٦Z	one) 2 Medical Examination the basis of examination and/or in and manner stated.			
] 3	*  *	295. Signature and title of certifier	29c. License number		ned (Month, Day, Year)
_		anel	O.C.M.E.	May 9, 20	10
20V	1	30. Name and address of person who completed cause of death (item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 F	Penn Street Pallimore MD 04004		
	10	31. Date filed (Month, Day, Year) 32. Rejissor's Signature	eni street, battimpre, MD 21201	<u> </u>	
Registra		MAY 18 2010	have		
	51	John The Land	IGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13<sup>ay</sup> Physician/ May Month 20ÎÎ Mildred Valis 12:05 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours July 12, 1936 Maryland 212-34-7250 73 **Director** Yrs. Usual Residence of Deceden permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must he mortified an one. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Towson 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Edgeview Rd. 21286 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 Divorced 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Keller Braun Susan James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Edgeview Rd. Towson, Md. 21286 Mr. Wenceslaus Valis/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 5-19-10 Owings Mills, Md. 4 Donation 5 Other (Specify) Garrison Forest Va. 21. Signature of Fune & Service License 22. Name and Address of FRuck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Immediate Cause (Final Onset and Death Physician/ east disease or condition resulting in death) 13 aMedical Due to (or as a consequence of). **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 ate has been signed by the page 2 should be detached certificate funeral director, this within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

Baltimore, Maryland 21215-0036

	١		autopsy prior to completion of cause o death?  1  Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?		26. Place of Death (Che	eck only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	tient 3 DOA Other: 4 Nursing	Home 5 Residence 6 X Other (Specify)
27. Manner of Death  1 Notural 5 Pending 2 Accident Investigation			28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

į										
ĺ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									
1	(Check	2 Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, dat	e and place, and due to the cause(s) and manner state						
ı	only one) 3 M Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
ı	29b. Signature an	d title of certifier	29c. License number	29d. Date signed (Month. Day, Year)						

Name and address of person who of death (Item 23a) (Type, Print)

Balto, MD 21204

6701 N. CHARLES ST. CRNP NEUSSA

32. Registrar's Signature

State Registrar

ျ

Certificate:

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G903, 5/18/2010, WS

State of Maryland / Department of Health and Mental Hygiene | | | 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Warph 0 D. L. may 12 20/0 336 Dra. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner YC 2 H,114 SILVEY Slovin mon Rosemar If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Yea 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 179-46-7660 1 □ M 2√2 F Director 54 Yrs. PA Aug.28 Usual Residence of Decedent the Marylend 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 17 is marked other than "natural", or items 23s or 28s-f show treumatic event, the Mudical Examinar must be notified at MD Montgomery Silver Springs Director 1 ☐ Yes 2 ☑ No 10e. Street and Number #R2 10f. Zip Code 10g. Citizen of What Country? -MD-1942 Rosemary Hills Dr.#2 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√2 No Specify: Specify Black 3 ☐ Widowed 4 ☑ Divorced Completed permit. Peges 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If them 27 le marked other than "natu, any Injury or other traumatic even." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business 12th N/A Corp Adm. Exec 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Be Thomas F. Waugh Doris Davis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 W. Evergreen Ave. #I1 Phila, PA 19118 Delores A. Waugh/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chelten Hills Cem 5/21/10 Phila., PA 22. Name and Address of Facility Beverly D. Cromartie F/S21. Signature of Funeral Service Licensee Que 2700 Edmondson Ave. Balto., MD 21223 a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ngive /Medical Due to (or as a consequence of): Examiner Saquentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner ettending physicien end for use es the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 XNo
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death ed by the e 5 Other (specify) 9 Unknown s been signed is Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1⊠Yes 2 No this s efter death.

I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1-Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitai within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) - E 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo ome 1000428 may 5010 15 ManRESSOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 529 mooms NBRECHER Silver 0 0901 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Maria Charlotte Warner Maÿ 1:00 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth Dec 16, 1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 T F Months Days Hours Min. 233-64-2416 Yrs Germany 83 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any ijury or other traumatic event, the Medical Examiner must have any one. 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No Harford Bel Air <u>Maryland</u> 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 21015 1135 Robin Hill Court USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No 1 ☐ Yes ( If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bell Atlantic Public Relations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Karoline Waldschmidt Joseph Mayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4517 Arabia Avenue Baltimore, Maryland 21214 Joan Parochetti, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/17/10 Baltimore, Maryland Signature of Funeral Service Lice Thomas Gregor Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, Ovarian ernu disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events southing in death). Examiner Due to (or as a consequence of) sician and burial-transit executed Due to (or as a consequence of): resulting in death) Last eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be or 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💢 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hos, in 24 hours o the Funeral Div completed filler 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Vithin 2 only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) R149194 17,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Nr Charles Grant Marian Towson. 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Lois Virginia Williamson 1:10AM 2010 Mas 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A UTIMORE 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HEALTheave AANES 9. Birthplace (State or Foreign Country) Indiana 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months 304-01-3521 Director Nov 14, 1916 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinal must be notified at once. 10a. State 10b. County Director 1 ☐Yes 2 No Maryland Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 709 Maiden Choice Lane, Apt-RGT-6208 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Laverne Burt ဥ Edna Maude Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2135 A Woodbox Lane Baltimore, Maryland 21209 Ray A. Williamson, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 05/14/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute respiratory failure hours disease or condition resulting in death) /Medical Examiner onacstive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ASCVD

Due to (or as a consequence of): requires that the death certificate be execut the burial-trail physician use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) the detached o 9 Unknowr icate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by COPD Or dependent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an certificate has autopsy perform Vital 1 □Yes 2 No 1 ☐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation the 24 hours after death Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 1/2001

State

a

Majden Choice In

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	F	1- For State Certificate of Death Registrar	_	g. No.	J Com 1					
Physician Medical Examine	-	1. Decedent's Name (First, Middle,Last)  Karen Lee Wheeler	2. Date of Deat Month May 9, 20	Day Year	3. Time of Death 1255 hrs					
	ı	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death 32 South Arlington Avenue  Baltimore		4c. County of Death						
Funeral Director	Ī	5. Social Security Number 216-92-8406 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs 46 Yrs. Months Days Hours Min		h(MM/DD/YYYY) 9. Bir						
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
	<u>.</u>	MD Baltimore Baltimore  10e. Street and Number 10f. Zip Code	I 10	ng. Citizen of What Cou	1 Yes 2 No					
th the Maryland  23a or 28a-f sh  notified at once		3300 Benson Ave., Apt. 315 21227		United St	ates					
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Jauna	11. Marital Status  1 Never Married  2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  3 Widowed  4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S.  If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No specify:		White, etc.	can Indian, Black,					
nours after fractions after fractions after fractions after fractions and fractions fr		3 Widowed 4 A Divorced It Yes, Give Year  15. Decedent's Education (Specity only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  1 Yes 2 X No specify:  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		Specify: Whi						
5-0036 ed within 72 hour tygiene. other than "natu	ald III	12 4 Nurse	/Final Billio B	Health	care					
21215-0036 suld be filed within 7 Mental Hygiene. marked other than re event, the Medical	8	John Miller, Sr. Chr	ristel M	anthey	7.0.1					
MD 21 nd 2 should alth and Me am 27 is ma aumatic ev	-	19a. Informant's Name/Relationship (Type, Print)  Stephanie Bafford — Daughter  185 Dunlap Rd., Pasa	adena, M	D 21122						
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Departation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Atlantic Crematory 5-:	Date 12-2010	20c. Location - City or Glen Burr	·					
Balti permit. Departm Importa injury o		21. Signature of Funeral Sovice Upon 2. Name and Address of Facility Ambrose Funeral Home, Inc.  1328 Sulphur Spring Rd., Arbutus, MD 21227								
Physician /Monitor	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and								
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Alcohol and methadone intoxication  Due to (or as a consequence of):  b.								
red fed fed fed fed fed fed fed fed fed f		dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated								
and and Eva	al EXa	events resulting in death) Last  Due to (or as a consequence of):  d.								
760, cate be execuphysician and the burial - tra		AMENDED 23a,PII,27,28a-f,per ME g904 6/18/1	LO_TT	23d. Date of delivery						
b. Box 687 the death certific by the attending p	Siciali	23b. Was decedent pregnant in the past 12 months?  1	ancy	Month D	day Year					
ires that the d signed by the be detached	<u>}</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to						
Division of Vital Records, P.O. tal. rate ding Physician: The law requires that the star ceath.  The Intercor: After this certificate has been signed by led in by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted by the funeral director.	najaidijion	pneumonia	24a. Was a	an 24b. Were au	topsy findings available ompletion of cause of					
Vital Recysician: The la		25. Was case referred to medical 26.Place of Death (Check	1 ✓ Yes 2		s 2 No					
f Vital Physician or this certi	2 L	examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 🗸 Other	: Scene					
vision of vr Attending Phore cath.  Frector: After the by the funeral in by the funeral fication: T	arion:	27. Manner of Death  1 Natural 5 Pending Investigation Investigation 1 Page 1 Pending Investigation 1 Page 2 No Pending Investigation Page 2 Pending Investigation Page 2 Pending Investigation Page 2 No Pending Investigatio	unk	ow injury occurred						
Division o spital r Atending hours a cr cath, neral Director: Afte filled n by the fune		3 Suicide 6 X Could not be determined Could not be determined (Specify) found at residence		treet and Number or Ru (ate) 3.2 S. Ar (re, MD. Ar)						
Division of Vital Records, P.O. Box 68760, To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours at creats.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Ź	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed (Moi May 10, 2010	nth, Day, Year)					
$\phi$		Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Stat Registra	~	31. Date filed (Month, Day, Year)  A 2010  A 2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year WILLIAM 38 Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOS PITAL BACTIMORE TIMORE Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 □ F 68 Months Hours Min June 15. 1941 West Virginia 216-36-1493 Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21220 216 Kingston Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XX Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Vietnam Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BG & E Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sarah Helen Hatchell James Roy Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code)
216 Kingston Road Baltimore Maryland 21220 Georgia Williams/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/19/10 Baltimore Maryland Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenses 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GRONARY Physician/ UTE disease or condition Medical resulting in death) **Examiner** 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Day Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPER TENSION 2 No 3 Probably 4 Unknown HYPER CEPID EMIA 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, pag 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify, Manner of Death
Natural
Accident
Suicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. m.0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frankish Square Drive Rusedale, MD 21237 RKINS

Registrar
DHMH 17 Rev 7/2009

State

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lola Weber 14:57 FM Medical 4a. Facility Name (if not institution, give 4c. County of Death Examiner 4b. City, Town, or Location of Death more timore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min. 12-08-1948 213-64-2670 **Director** 61 Usual Residence of Decedent show 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Lansdowne 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 3229 Bero Road 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White "natural". ₩XWidowed 4 □ Divorced Year or Dates event, the Me lical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Important: If item 27 is marked other than ' any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Clerical Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lawrence Shugars, Sr. Nellie Keithley 19a. Informant's Name/Relationship (Type Print)

Weber Heff Ler / Daughter f Health and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3229 Bero Road, Lansdowne, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State W. Arundel Crematory | 05/15/2010 Odenton, MD 4 Donation 5 Other (Specify) Signature of Evneral Service Licensee 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service,
4023 Annapolis Road, Halethorpe, MD 21227 M01452 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ xsanguination tracheo innominate Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 morths?
1 Yes 2 No Day Year 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes 2 🗹 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 2 No Slage 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

(Check one ulne

29b. Signature and title of certifier

Panagioti

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

18

fat the time, date and place, and due to th

29d. Date signed (Month, Day, Year)

2010

29c. License number

Certifying Nurse Practioner To the best of my knowledge, death of

Izevele

etAd cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 715 PM DOROTHY NORMA WINFIELD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bel Air Health and Rehabilitation Cente BelAIR mo Harton 2/014 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 XF Days Hours Min. July 30 212-28-2619 Mary Land Director 79 Yrs. 1930 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1308 Scottsdale Drive Unit R 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Alexander Johns Helen May Stinchcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Winfield / Son 1615 Boggs Road, Forest Hill Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cem. 5-19-10 Baltimore, Maryland neral Service Licensee 21. Signature McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYDOXIC disease or condition resulting in death) Medical Due to (or as nuence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Dav Year 1 Yes 2 4 9 Unknown 2 40 been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 24 hours after death. Funeral Director: After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 Miknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check y one) Hospital 2 🗆 🛶 Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantitioners to the best of any knowledge, detit d at the time date and black and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 14/10 C 855 32 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Obert 31. Date filed (Month Day, Year) State

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day \_Year Irena (nmn) Wolosiuk 8:58P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center more Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 26, **Funeral** Birthplace (State or Foreign Country) Birtri Day, Year) 1953 1 □ M 2 🔀 F Months Days Hours Min. Director 046-72-4285 56 Poland Usual Residence of Decedent shov 10a. State 10b. County with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎦 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Rosefield Court 21014 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc <u>چ</u> 1 Never Married 2 X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receiving Clerk Retail Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Mieczyslaw (nmn) Chrabolowski Helena Julia Kozlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Wolosiuk / Husband Rosefield Court, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 5-18-10 Towson, Maryland . Signature of Fur ral Service 22. Name and Address of Facility McComas Funeral Home, Ugua Broadway, Bel 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCARCINOMA DE disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PROGRESSIVE ILEUS 1 Tyes 2 No 3 Probably 4 Unknown URINARY TRACT INFECTION 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of LACTIC ACIDOSIS performed' 2 🗆 No Yes 2 No Was case referred to medical

tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 24 hours a

Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No Other: ပ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, 5 Pendina Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 1-0 1 COL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER DRIVE TOWSON. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of M	laryland			it of Hi e of D	ealth and N eath		giene Reg. No	201	0	151	33
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	Medic Examin		4a. Facility Name (if not institution,	give street and number)			-		Location of Death			. County of D			Zam
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. las		If Unde		If Under 24 Hrs. Hours Min.	8. Date of Bir	th W Mearl	Balt 9.	Birthpl	ace (State or	Foreign
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10a. State 10b. County 10c. City, Town or 10c. City													10	d. Inside City	
	a or 28 be notir	al Dire	10e. Street and Number		1.0	100016	10f. Zip	Code		T	10g. Cit	tizen of What			2 136110
	ath with	unera	12216 Don	12. Was Decedent	Ever in U.S.	13 W		1136 lent of His	panic Origin? (Sp.	ecify Yes or No-		U.S		n Indian	
2020	ırs after de ural", or ite il Examine	by	1 Never Married 2 Marria 3 Widowed 4 Divorced	Aumond Enver-0	No	1		ify Cuban 2 🗶 No	panic Origin? (Sp., Mexican, Puerto Specify:	Rican, etc.)		Black, W	hite, et	tc.	
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7 7 7	d withir tygiene ther thi nt, the	Be Co		College (1-4 or	5+)	B	lookk	eeper				Constr	ист	ion	
	17. Father's Name (First, Middle, Last)  Albert Bleakley  Albert Bleakley									's Name (First, Middle, Maiden Surname) Helen Jones					
Mar	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship (Type, Print) 19c. Mailing Address (Street and Number or Relationship (Type, Print) 19c. Mailing Address (Street and Number or Relationship (Type, Print)) 19c. Mailing Address (Street and Number or Relationship (Type, Print))												Zip Ço	ode)	
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	<u> </u>		23a. Part 1. Enter the disease, or	complications that cause	d the death.	Do not ente	116	05 Re	of Facility Funeral istersto	or respiratory ar	Owi	ngs M	ijĮ.	s, Md.	85
1	Physician/ Medical		shock, or beart failure. List o Immediate Cause (Final disease or condition resulting in death)	_a Mota	state	ic c	arci	noid	+um	or				Interval Betw Onset and De	
	Examiner	<u>.</u>	Sequentially list conditions	Due to (or as	a conseque	ence of):									
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2	eath certificate be executed attending physician and I for use as the burial-transit	edical Examiner	resulting in death) Last  Due to (or as a consequence of):  d												
5	rtificate ing phy: e as the		IF FEMALE:	0.							Т		_		
YOG .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3 🗌	Ectopic   Other (s)					23d. Date of Month		*	ear
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מ	sician s certifi lirector	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	iont 2 🗆 🗆	R/Outpatien		Other	ce of Death (Chec 4  Nursing Ho	5 6					
	nding Phy ath. r: After this e funeral c		27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig	28a. Date of inju (Month, Da	ury 2	28b. Time of injury		8c. Injury a	at	28d. Describe h			еспу)		
N N N	al or Atte s after de I Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ			ne, farm, stre	et, factor	, office		28f. Location (S City or Tov			Rural F	Route Numbe	ır,
	e Hospit n 24 hour e Funera	Medical	l (Check 2 ∟ <b>Medical E</b>	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination a	and/or investi	igation in	noinian vm	<ul> <li>death occurred a</li> </ul>	t the time, date a	and place	and due to the	ne caus	se(s) and man	ner stated.
	To th withir To th comp	2	only one) 3 □ Certifying 29b. Signature and title of certifier 30. Name and address of person v 31. Date filed (Month, Day, Year)			Jago, a	290	. License	number	, 340 10 11	29d. Dat	te signed (Mo			
			30. Name and address of person v	who completed cause of c	death (Item 2	23a) (Type, P	rint)	VL	2 11			3-	5-17-10		
	- 01-		31. Date filed (Month. Day Year)	MTree Rd	ar's Signatu	whe is	145	(V	relto,	Md	2/2	roj			
	Stat Registra	ar	WAY	18 2010 - 2	مناسخته	1	bar	les!							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 16 3. Time of Death Physician/ Diane Welsh May 2010 5:45 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**□ F Months Days Hours Min. 12/1/1951 Mary land **Director** 212-60-5643 Usual Residence of Decedent or 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho Director 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9745 Deltom Court 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify. 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)
Payroll Specialist Elementary/Seconday (0-12) College (1-4 or 5+) Accounting 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. Once. Clyde Carter Claire T. Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9745 Deltom Court Baltimore, Maryland 21234 Timothy F. Welsh, Sr. / Husband 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Garrison Forest Vet. |5/25/2010 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Proysician/ 0101 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Month ate has been signed by the a page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform certificate 1 🗌 Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Certificate: To 1 🗆 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence after death.

Director: After this filled in by the funeral 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Munawi, up 0050 5/16/10

Registrar
DHMH 17 Rev 7/2009

State

Gento

31. Date filed (Month, Day, Year,

670

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Vear **Physician** HELEN C WYLER MAY 9:20 A M 2010 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 212-18-8297 90 4/14/1920 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 □ No Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a 6711 PARK HEIGHTS AVENUE, #313 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON DEPARTMENT STORES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H i Item 27 is marked ott Be WILLIAM CROZIER ROSE EDLAVITCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES WYLER/SON 1504 REGESTER AVENUE, BALTIMORE, MD 21239 20b. Place of Disposition (Name of certain R cronting other place) Date Pages 1 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CONGREGATION 4 Donation 5 Other (Specify) 5/16/2010 OWINGS MILLS, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last andia venu Due to (or se a consequence of) Examiner that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for ( in the past 12 months' 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con ute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 - 0 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate I 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 | Inpatient P 2 ER/Outpatient 3 DOA this funeral c 27. Manner death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 1 - atural 5 Pending death. investigation 1 Yes 2 No ai or Attend s after death. ii Director; / 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 631615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raltimoro mes Tacos 32. Registar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2010 Ap 497 24, 11:00 P M Douglas Paul Argy Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2495 Wintergreen Way Gambrills Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🛛 M 2 □ F Months Days Hours Mar. 27 New York 217-70-8966 54 Yrs Director 1956 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Gambrills 1 Yes 2XX No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2495 Wintergreen Way 21054 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ь Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Vacuum Sales and Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Bertram Argy Phyllis Ann Reid other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Marilyn K. Argy/ wife <u>2495 Wintergreen Way, Gambrills, Md.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Resurrection Cemetery 4/28/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ MFLANDHA OF SKIA METASTATIC BRAIN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) transit. that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown the g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 No Hospital Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Hospital or Attending | 24 hours after death. To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D21336

3

3altimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

State Registrar 31. Date filed (Month, Day, Year)

40 8028 RITCHE

, SUME 134, PASADONA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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			For State Registrar	State	of Mar	yland / Dep Ce	artmer <i>rtificat</i>			nd Me	ental Hy	giene Reg. No	0010	15127	
	Dhysiois	n/	1. Decedent's Name (First, Middle				· · · · · · · · ·	0 01 2			2. Date of De	eath	1	3. Time of Death	
pit.	Physicia Medic	cal	James Eugene 2  4a. Facility Name (if not institution				14. 63		1 11 1	ىل	77.77			0645 AM	
2	Examin	ier	Washington Co	inty Hosp	ital		Н	ager	Location of stown	Death	4c. County of Dea Washin				
	Funeral Director			6. Sex M M 2 □ F	7. Age (In	yrs. last birthday) 72 Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours		8. Date of Bir Sept . 2	th Brearb	9. Birthplace (State or Foreign Mary Land		
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Change of the county 10c. City, Town or Location								<u></u> :			10d. Inside City Limits			
	Maryl 28a-f rotified	Director	Maryland Washii	ngton		Sharpsbu:	<del>-</del>							1 ☐ Yes XX No	
	10e. Street and Number 10f. Zip Code 110g. Citizen of What Country? 10f. Zip Code 110g. Citizen of What Country? 10g. Citizen of What Country? 11d. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,										ountry?				
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and 2	be filed within ental Hygiene. ked other than ic event, the N	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)										1414		
Maryland 21215-0036	Richard Anderson Mary Viola Davis    P										(ip Code)				
Rnea Anderson - Wife 16509 Woburn Road Snarpsburg, MD 21782  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Method of Disposition 20c. Location - City or Town, State 20c. Location - City or															
20a. Method of Disposition  XX Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Services tensor  22. Name and Address of Facility  22. Name and Address of Facility  23. Name and Address of Facility  24. Sonococheague St. Williamsport, MD									,P.A.						
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that	caused the					_				Approximate Interval Between	
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	and		140-	1	VVVLJ	T				Onset and Death	
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to	(or as a co	insequence of):	AL	. 10.	77	100	il.				
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200	physic the bu	edica		d											
. Box 68760	or Attending Physician: The law requires that the death certificate be infected.  Interded the death.  The laws been signed by the attending physic in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e Birth 2 Ĺ gnant at tin	Fetal death 3	Ectopic Other (s		у				23d. Date of de Month	elivery Day Year	
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n of V	ding Phys h. After this funeral dii	ate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Dat (Mo	Inpatient of injury oth, Day, Ye	2 ER/Outpatie 28b. Time o injury	f 2	8c. Injury Work	4 ∐ Nurs ≀at ?	28	e 5 Resi		Other (Spery occurred	cify)	
1 Sinpatient 2 FR/Outpatient 3 DOA State   Nursing Home 5 Residence 6 Other (Specify)									ural Route Number,						
	Process of the control of the cause (s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.  3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated.									cause(s) and manner stated					
	To the within To the comp	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)													
	•		30. Name and address of person	who completed as	ise of door	(Item 22a) (Time	Print\	D.	5824	07		5	12/2	010	
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	Sta Registra		31. Date filed (Month, Day, Year)		Registrar's	Signature	alle	/	, ,						

DHMH 17 Rev 7/2009

10-03427
Marie Claire Avery

0-03427	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.																	
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		1- For State Certificate of Death	R	eg. No.	10 1343													
Physici		Decedent's Name (First, Middle,Last)	2. Date of Dea	th	3. Time of Death													
Medical Exam	iner	Claire Marie Avery	Month May 3, 20	Day Year 110	1725 hrs													
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deal	th	4c. County of Dea	ath													
		5425 Wisconsin Avenue P3 Chevy Chase		Montgomery	•													
<b>Funeral</b>		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Bi	th (MM/DD/YYYY) 9. E	Birthplace (State or Foreign													
Director		563-86-3504 1 M 2 X F 60 Yrs. Months Days Hours Mi	n. Feb. 1	, 1950 T	Country) 11inois													
		Usual Residence of Decedent			1111010													
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Aaryland 28a-f show 1 at once.	cto	10e. Street and Number 10f. Zip Code	<u> </u>	0g. Citizen of What Co	ountry?													
with the Maryland ns 23a or 28a-f sho be notified at once.	<b>Funeral Director</b>	11914 Fieldthorn Court 20194		United Ct.														
vith t s 23a	<u></u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	nacify Voc or No	United Sta	arcan Indian, Black,													
ath v	ne	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	White, etc.														
r, or		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1972–1983 1 Yes 2 X No specify:		Specify: Cau														
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Physician /Medical		failure. List only one cause on each line.		est, shock, of fleat	Approximate Interval Between Onset and													
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certi	gi	past 12 months?	ancy	Month	Day Year													
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n of ding Pl After funera	ᇹ	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe h	ow injury occurred														
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H T I D CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Constitution one																		
											2	29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	onth, Day, Year)			
										2		O.C.M.E.		May 4, 2010				
		30. Name and address of person who completed cause of death (Item 23a)																
Col.		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI	D 21201															
		31. Date filed (Month, Day, Year)  32. Registrar's Signature																
Regist																		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 30 Day 2010 Year Alston 8:03 А м Janet Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Castle of Love Assisted Living Bowie Social Security Number 7. Age (In yr - last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 02/03/1917 South <u>Carolina</u> Director 239-36-2846 93 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. our or or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Ft. Washington 1 ☐ Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1132 Windermere Court 20744 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 KNo Specify: **Black** 3 ₩Widowed 4 □ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 years Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kiasha Hough / Granddaughter 1132 Windermere Court, Ft. Washington, Maryland 20744 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 05/01/2010 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year 1 Yes 2 No 9 Unknown sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No Yes 2 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home After this 5 Residence Manner of Dear . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investi**g**ation Director: 6 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number of death (to 123a) (Type, Print) 30. Name and address of person who completed cause 6934 Aviation Blvd. Glen Burnie, Maryland MD Harold Bob (Month, Day, Year 32. Registrar's Signature

State

Registrar

MAY 0 4-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Orpha Short Atwell 0340  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Cecil Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Min. FEB 13, Year 1923 West Virginia Director 232-38-2409 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 76 Alda Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 💢 No Maryland 21215-0036 1 Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Garment Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas J. Short Martha Kennedv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Bowen/Daughter 76 Alda Drive, Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) 2010 Elkton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ hemontheel mercranical Medical resulting in death) Due to (or as a consequence of) Examiner responentia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (di as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Exam pertension that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Abrill extron 3 coumadin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐No 24a. Was an autopsy Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2√2 No မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69048 12 2010 Mulin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11ctan\_ MD 21921 31. Date filed (Month, Day, Year) 32. Regi State 2010

DHMH 17 Rev 7/2009

Registrar

Dr

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY **Physician** Helen S. Altvater 2010 3:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3893 Green Hill Church Road Ouantico 8. Date of Birth (Month, Day, Year)
Dec. 20,1926 If Under 1 Year ] If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 1 F 83 203-18-8958 Maryland Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madeal Examinar must be nutilised. Director 1 □Yes 2X TWNo Ouantico MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21856 3893 Green Hill Church Road United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 72 hours after 1 ∐Yes 2x∏xNo If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify: White ð Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Time Office E.I. DuPont i 2 should be filed with and Mental Hygier
7 is marked other th 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Hrynko Julia Nester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21856 19a. Informant's Name/Relationship (Type. Print) Charles William Altvater/Spouse 3893 Green Hill Church Rd., Quantico, MD permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trae Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of Good CounselCem. 05/05/10 Secretary, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Framptom Funeral Home, P.A. Coale Federalsburg, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA LUNG 3 MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **OF Natural** 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D36576 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) ms RONALD P. 560 RIVERSIDEDRIVE IRHUITE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 7 25, Day 2010 5:20 Ам William C. Bickford Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Collington Health Care Bowie Social Security Number Sex 1 X M 2 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 87 Months Hours Min August 193-18-2644 Director **~**1922 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1X Yes 2 □ No Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Road 20721 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 No Specify: White Specify. 3 Nidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) DC Government Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Planner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William M. Bickford Minnie Christ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Townsend/ Daughter 1631 Rock Bluff Road Hixon, TN 37343 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4/26/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of uneral Se 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se - undo a 2000 Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>~</u> Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has t autopsy performed After this certificate Yes 20 æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 ANO ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural iniury 5 Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29c. License number AH 64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don H. Yablamowitz, M.D. Goodbuck Road \$300 Lanham, mo IVA 3116

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per fh g914 4-11-11 vt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 26, 2010 8:30 P M Edith Joyceline Butler 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Annapolis Somerford Assisted Living Facility Anne Arundel 5. Social Security (1512) 593-11-0513 8. Date of Birth (Month, Pay, Dec. 18, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1919 Days Months 1 □ M 2 🖸 F Dec. Bermuda 90 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 2717 Riva Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold Simmons Alice Simmons Desilva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1723 Dryden Way Crofton, MD 21114 Roderic Butler/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Johns's Church Cemetery 5/8/2010 Pembroke, Bermuda

22. Name and Andress of Facility Robert E. Evans Funeral Home 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ETASTATIC CORVICAL CANCOR YPAR disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COLON CANCER 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DOMENT 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSISTED (Specify) UI 2 No Hospital: Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3□ DOA LIVING. 1 ☐ Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hi
Important; If Item 27 Is marked oth **Physician** /Medical Examiner Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

77 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

al Hygiene.

Funeral Director

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Completed

Be 2

filed within 72 hours after death with the Maryland

attending physician the use į the has certificate director, this filled in by the funeral To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

or Attending Physician;

þ

Completed

Be

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who comple

APR 2 9 2010

State Registrar 29c. License number

29d. Qate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jo N Month APRIL 0/31 PM ROBERT THOMAS BRITTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1 Brett Court Apt 108 Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. (Month, Day, Year Jan 30, 1 Director 219-84-1333 50 1960 England Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Brett Court Apt 108 21221 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 X Never Married 2 Married \$ Yes Yes 2 X No Maryland 21215-0036 1 Yes 2X No Specify: and Mental Hygiene. If Yes, Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important. If item 27 is marked of
any injury or other traumatic eve 2 William Britton Carole Hamilton Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. Chubb/mother 6802 E. Paseo San Andres Tucson, Arizona 85710 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) inal Journey Crematory 5/6/2010 Woodbine, Maryland 21. Sign e of Funeral Service Golog Homes Cremation Service P.O. Box 784 stinai M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner 30 YEAR) OBESITY Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last HEPATITIS or Attending Physician: The law requires that the death certificate be executed 6 MONTH! 0 anding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year the a 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown s been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? certificate 2 X No 1 🗌 Yes 2 🗌 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes မ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) hours after death.

uneral Director: After this
d filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 1/Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MAY 4 2010 RES -000

Registrar
DHMH 17 Rev 7/2009

State

4940 Eastern Avenue Baltimore, Maryland 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 5 2010

32. Registrar's Signature

Justin Chronister DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Day Physician 2010 29 9:05 A M Henrie Ethel Blake /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catered Living Ocean Pines Worcester | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8/5/1917 | 7/24 | 8/5/1917 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 | 1/24 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 213-38-2794 92 ΤX Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exp., in er must be notified at 1 □Yes 2 XNo Director MD Worcester Ocean Pines 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code death with 10 Clipper Ct. 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No 2 should be filed within 72 hours after of and Mental Hygiene.

is marked other than "natural", or itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Shiller Sadie Esterak ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an item 27 i Scott Blake / son 10 Clipper Ct., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or conce. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4/30/2010 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lucenses 22. Name and Address of Facility Burbage Funeral Home mon 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** emento years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner eumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a P.0. 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an rector, page 2 s 1 □ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:  $1 \square Inpatient$   $2 \square ER/Outpatient$   $3 \square DOA$ 1 Yes 2 No Assited Living Certification: To After this funeral 27. Manner of Death 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t pletely filled in by the funera 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Eccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier d0067227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Racetrack Rd Berlin, MD BA 3 anielle 11107 Orr MD 31. Date filed (Month, Day, Year) APR 3 0 2010 Registrar's Signature State

DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 3:22ам Shirley Eastman Borseso April. 30. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Rockville Montaomeru 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min 1 □ M 2 🛛 F Months Days Hours 578-44-2642 84 Director April 17, 1926 Utah Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location show 10b. County 10d Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be rediffed at Director 1 ☐ Yes 2 🛛 No Maryland Montgomeru Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Baltimore Road 20850 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 ∐Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No <u>ک</u> Specify: 3 X Widowed 4 □ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, I'm Mer Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ukn Be Kathrun A. Roberts ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Linn - Daughter 10826 Antigua Terrace, #201, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 05/02/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Necrotic Pulmonary Disease month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician the death certificate be Physician/Medical g 2 as use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? /es 2 \ No certificate 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Living i 24 hours after death.

e Funeral Director: After thiletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

To the within 2

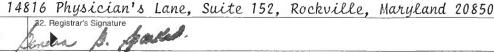
State Registrar 31. Date filed (Month, Day, Year) MAY 03 2010

Shama Mittal, MD,

Shama

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D0061382

29d. Date signed (Month, Day, Year)

May 1. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Month Year Bernard Thaddis Brunson April 22, 1920 hrs. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel **Annapolis** 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea Months Hours Min. Days 1**X** M 2 □ F 59 578-68-4676 South Carolina May 26,1950 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 9808 Hillandale Way United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Specify: Black 1 □Yes 2X No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Federal Emergency Elementary/Secondary (0-12) College (1-4or 5+) 4 years Human Resources Representative Management Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thaddis Brunson .Iometa Whetston Edward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9808 Hillandale Way; Bowie, Maryland 20721 Sharon Lee White Brunson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 1,2010 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Lincoln Memorial Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility R. N. Horton Company Morticians, amus Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erenca Due to (or as a consequence of): Sequentially list conditions, dany wach g to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecuence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2-1No 1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Examiner Attending Physician: The law requires that the death certificate be executed

Department of Health and Mental Hygien. Important: If Item 27 is marked other that any injury or other traumatic survent.

**Physician** 

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Exeminar innet be notified at

Baltimore, Maryland 21215-0036

/Medical

burial-tran attending physician for use as the buria cate has been signed page 2 should be det has certificate director this funeral c After

sion of Vital Records, P.O. Box 68760,

Physician/Medical <u>م</u> Completed Be Certification: To

Medical

MAY 0 3 2010

	0	Div
State	0	completely filled in

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 | Yes 2 | 1√10 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1. Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Stephe Olexo Annapolis, Maryland 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Francis J. Boyne 10:15 AM 29 2010 Medical April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Nursing Home Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours 93 080-07-7720 Yrs Director 1916 Brooklyn, NY Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County frector 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔯 No Maryland Prince George's Hyattsville ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Cox Avenue 20783 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 
Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" White 3 X Widowed 4 Divorced WWII Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Mechanical Engineer 4 Be filed 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed.
Department of Health and Mental H.
Important: If item 27 is marked ott
any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Joseph Boyne Gertrude Buckley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Boyne / Son 6620 S. Clifton Road, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 5/3/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): skian and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ō Month detached the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure Completed 1 Yes 2 No 3 Probably 4 X Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsy performed? Yes 2 X No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 🗵 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 7 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State

Registrar

20912

Nasreen Mustafa Kango, 7701 Carroll Avenue, Takoma Park, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Date filed (Month, Day, Year,

MAY 0 4 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 29 2010 au KATHERINE E. BROWN 1741 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13138 MUSKRATTOWN ROAD BISHOPVILLE WORCESTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 6-23-1947 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2 🕅 F NEW YORK 217-48-9948 62 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Im M. Iteal Exprine must be nutified at appres. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13138 MUSKRATTOWN ROAD Funeral 21813 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No ģ Specify: WHITE 3 Widowed 4 NDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 SCHOOL TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALLACE T. BROWN DOROTHY E. DEAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. BURNS/EXECUTRIX 32633 DUPONT HWY, DAGSBORO, DE. 19939 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State MELSONS CREMATORY 4-30-10 4 ☐ Donation 5 ☐ Other (Specify) FRANKFORD, DELAWARE 21. Si mature of Punctal Service Licensee MELSON FUNERAL SERVICES, LTD 43 THATCHER STREET, FRANKFORD, DE. 19945 23a. Part 1 Engl the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest should be reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung /Medical Due to (or a consequence of): Examiner Smoking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequi Examine burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ၉ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760. the signed by the cate has page 2 s this certificate After within 24 hours after death

To the Funeral Director: 
completely filled in by the f

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print) DN 15 31. Date filed (Mont

State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Virgil Howard Cole 2. Date of Death 3. Time of Death Physician/ April 30 Day 2010 Year 2:00AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 Month Day Years Minnesota 475-28-0643 87 Yrs. Director Usual Residence of Decedent 10a. State 10b. County or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Rocky Ridge 1 🗆 Yes 2 🛱 No 10e, Street and Number 10f. Zip Code rms 23a or 10g. Citizen of What Country? Funeral 15554 Motters Station Rd. 21778 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner rmed Forces?
Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify: Completed 3X☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Department of Health and Ment. Important: If item 27 is marked any injury or other reconnections. ည Albert Cole Johanna Loe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15554 Motters Station Rd., Rocky Ridge, MD 21778 Dean Cole/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State East Cemetery 5-7-2010 Hanley Falls, MN 4 ponfation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., of Funeral Service Licensee M00817 PO Box 128, Charlotte Hall, MD 20622 Part 1. Intercipe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzmeimer's Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) thember D0067788 5.10.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Leena Rao Kodali.</u> 29449 Charlotte Hall Rd., Charlotte Hall, MD 20622 State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sadie Garrett Curtis 2010 April 28, 4:03 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Severna Park Household of Angels Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 15,1931 **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2**X** F Months Days Hours 217-52-2507 **Director** 78 Yrs. Pennsvlvania Usual Residence of Decedent show 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits r 28a-f sh notified a MD Anne Arundel Severna Park 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code items 23a or ner must be r 10g, Citizen of What Country? Funeral 21146 16 Beach Road USA within 72 hours after death Was Deceue. Armed Forces? Vas 2 X No 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 X Married ò þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Homemaker Home of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Milan Garrett Eunice Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Severna Park, MD 21146 William R. Curtis / Husband 16 Beach Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprile 29, 1 Burial 2 Cremation 3 Removal from State Metro Crematory, INC. Baltimore, MD 4 Donation 5 Other (Specify) 2010 Signature of Eugeral Service Lice see Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ rebrows disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 0 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has autopsy performe Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Assisted Living 2 Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Tyes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KWY ANNAPOLIS, MD OBEK 2002 Registrar

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29c. License number O.C.M.E.  May 1, 2010  30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Registrar		Hosp 24 hou Fuoca		00- 0-46	nysician: To the bes	t of my know	/ledge, dea	th occurre	ed at the time, da	ite and pla					s state	d
29c. License number O.C.M.E.  May 1, 2010  30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  Registrar		o the o the omple	ig	one) 2 Medical Exam	miner:On the basis of	of examination	on and/or in	vestigatio	n, in my opinion,	, death oc	curred at ti	he time, dat	e and p	lace, and due	e to the	cause(s)
30. Name and address of person who completed cause of death (Item 23a) Pamelá E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State Registrar  31. Date filed (Month, Day, Year)  A 2010  32. Fegistrar's Signature		H 3 H 5	ž	29b. Signature and title of certifie					29c. License	e number		-	29d	. Date signed	(Mon	th, Day, Year)
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		State     Registrar  1. Decedent's Name (First, Middle, Last	4)	Ce	rtificate of		2. Date of Deat	eg. No. CUIU	3. Time of Death			
Physici		-	red		Culn C		Month 5	Day Year 1 2010	T) 4			
/Medic Examir		4a. Facility Name (If not institution, give			Culp, S	or Location of Death		4c. County of Dea	7.55			
		7463 New Hope Roa	ıd		Wi	llards		Wicomic				
Funeral		5. Social Security Number 6. Se					B. Date of Birth (Month, Day	9. Bir	thplace (State or Foreigountry)			
Director		220-12-2481 Usual Residence of Decedent	8	4 Yrs.			8-19-19	25	Virgini			
land ow		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits			
Mary a-f sh	to	MD Wicomi	CO W	illard	le				1 ☐ Yes 2X No			
or 28	Director	10e. Street and Number	.00	IIIaic	10f. Zip Code		1	0g. Citizen of What Co	ountry?			
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Than "natural", or items 23a or 28a-f show ant, the Mealcal Examinar must be notified at		7463 New Hope Roa	.d		21	874		USA				
er dez	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. <b>44</b>	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec oan, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Am- Black, Whit				
rs afte	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No 194 If Yes, Give Year or Dates: 194		1 □Yes 2X No	Specify:		Specify:	White			
2 hou atura		15. Decedent's Edu	cation	16a. Dece	edent's Usual Occu	pation		16b. Kind of Business	/Industry			
hin 7. e. an "n	agr.	(Specify only highest grad	College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of working ed)	7					
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be fill Hall Hed out	Be	17. Father's Name (First, Middle, Last)		_		18. Mother's Name (	First, Middle, I	,	_			
hould d Mel mark matic	ပ္	William F  19a. Informant's Name/Relationship (7)	ranklin	1	11p	Sadie t and Number or Rural	Davita Number		avis			
nd 2 s Ilth an 27 is r trau		Fran Smullen - Dau		1		Road, Will						
s 1 ar f Hea item	20c. Location - City or											
1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State									Maryland			
89 <b>589</b>		Melissa Xpu		ury, Maryl								
		23a. P. t1. Enter the disease, or coop shock, or heart failure. List o	ing, such as cardiac or	respiratory arr	est,	Approximate Interval Between						
Physician		Immediate Cause (Final disease or condition resulting in death)	Almerosder	241	CAUSITUA	scular.	H SEL SI	7	Onset and Death			
/Medical Examiner		resulting at death)	Due to (or as a consequ									
	er	Sequentially list conditions, b b b Due to (or as a consequence of): cause. Enter Underlying										
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		ŕ								
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eath certificate be executed attending physician and for use as the burial-transit	lical		d									
ertific ding p	Physician/Medica	IF FEMALE:	200 16									
attendation	ian/	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	☐ Ectopic pregnand ☐ Other (specify) _			23d. Date of de Month	livery Day Year			
the de y the ched	ysic	1 □Yes 2 □No 9 □ Unknown	9 Unknown	eatti 51	Other (specify) _							
e law requires that the de has been signed by the e 2 should be detached	by P	Part II. Other significant conditions co	ntributing to death but not resu	llting in the u	ınderlying cause gi	ven in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?			
quire: en sig uld be	ed b						1 □ Y€	es 2. <b>11√1</b> 0 3. □ F	robably 4 🗌 Unknow			
law re as be 2 sho	Completed						24a. Was a	n 24b. Were a	utopsy findings available			
The ate h	E C						perform		completion of cause of			
Iclan: certific ector,	Be (	25. Was case referred to medical examiner?	de anital:		l ou	26. Place of Death (						
Phys this rat dir	2:	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	III 3 LI DOA			ence 6 Other (Spe	ecify)			
ding th. After	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Wo	rk? Yes 2 No	id. Describe no	ow injury occurred				
Atter r dear ector	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me, farm, st				treet and Number or R	ural Route Number,			
safe safe al Din	Certification: To	4   Homicige	building, etc. (Specify	"			City or Town	n, State)				
the H hin 24 the F	Medical	one)	and manner stated.									
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29b. Signature and title of certifier	1-11-12	11.12	29c. Licens	se number	2	9d. Date signed (Mon	tn, Day, Year)			
WHY.		30. Name and address of person who co	ompleted course of death (11	001/	Print\	36014		43/10				
D. AM		Manes of person who co	tudua 106	WI (Type,	1.001 31	4 504 B	Salla	buy &	115 20 50 4.			
Sta	te	31. Date filed (Month, Day, Year)	32. kegistrar's Signat	urg 1	a. N.							
Registr	ar	29b. Signature and title of certifier  WMM W  30. Name and address of person who co  MM G M M  31. Date filed (Month, Day, Year)  NAY 0 4 20	TU Knews ,	J. 19	64.5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 30 2010 JO ANNE ELIZABETH BAMBARY COLLIER 10:55PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OUEEN ANNE'S 122 EAST MAIN STREET **STEVENSVILLE** If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Min. Days Hours APRIL 19. MARYLAND Director 218-34-9532 1939 71 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No QUEENSTOWN **MARYLAND** QUEEN ANNE'S 10e. Street and Number 10f, Zip Code 0 10g. Citizen of What Country? Funeral 23a UNITED STATES 108 MELVIN AVENUE 21658 items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married ō WHITE 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) lith and Mental H 27 is marked or r traumatic eve ၉ EVA JEWELL ROBERT BAMBARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 108 MELVIN AVENUE, QUEENSTOWN, MARYLAND 21658 WILLIAM LEWIS COLLIER/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State EVENSVILLE CEMETERY 2010 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at line. e diseas., or complications that Interval Between Onset and Death shock, or hea Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) Live Birth 2 L. Fetal Geal Pregnant at time of death in the past 12 months? Month Day Year ned by the a detached for 2 Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be dev 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ → 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? DAUGHTER RESTDENC 1 Yes Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 👿 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Day Month 1:30 ам Virginia Ann Craig April 27, 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Laurel Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours 84 **Director** 403-26-2154 11/04/1925 West Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Havre de Grace Harkord 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4223 Wilkinson Road 21078 U.S.A. Funeral filed within 72 hours after death the Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify ģ 3 X Widowed 4 ☐ Divorced White. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney Stevenson Ida Gerhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2024 Mayflower Drive, Silver Spring, MD 20905 Jack Paul Craig - Son 20b. Place of Disposition (Name of St. Mark & Epus Copal 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 05/03/2010 Silver Spring, Maryland Church Cemetery 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Amensee Rue 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION **Physician** PNEUMONTA dons /Medical Due to (or as a consequence of): Examiner Cerebro vascular Years acudent Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence on Examiner burial-transit Years HYPERTENSION and Due to (or as a consequence of): attending physician Physician/Medical the as IF FFMALE use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 🗷 No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has was a autopsy performed? certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 🛛 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

certificate be executed P.O. Box 68760, or Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: after death.

Director: /

within 24 hours aft To the Funeral Di completely filled in

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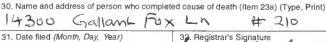
Medical

31. Date filed (Month, Day, Year) Registrar

29a. Certifier

14300

29b. Signature and title of certifier



and manner stated.

件	210	Bowie
Signature	ba	Ked

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

5 3411

Shesadri

MO

29d. Date signed (Month, Day, Year) 27K

2010

APRIL

20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ April 20 6:15 P M Barbara G. Carter Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death Examiner 4c. County of Death #103 2,850 GEOR 410 SILVEY W and S & Dowell F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 8, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 □ M 2 🖾 Days Director 578-58-7868 Usual Residence of Decedent 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 United States 9820 Georgia Avenue #103 Page 1 and 2 should be filed within 72 hours after death \text{ment of Health and Mental Hygiene.} ant If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert G. Carter, Sr. Alice White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Albert G. Carter, 11316 Ft. Washington Rd. . Apt. 310 Ft. Washington 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aprilate 30. 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or once, Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln Memorial 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE 20019 Washington, DC 23a. 27 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ SC disease or condition resulting in death) <u>m</u> Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 2 🗌 No Yes Hospital or Attending Physician: <sup>-</sup> 24 hours after death. Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. **Check** Cartifying Nurse Praction ath cionimid at the time, date and plane, and due to the cause(s) and higher as state ature and title of certifie 29d. Date signed (Month. Dav. Year) 1200428 M MO OME 2010 DOCK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRE , mo omE

State Registrar

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year)

MAY 0 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day George Castle 11:15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Center Laurel Prince Georges If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Months Days Hours Min Director 579-50-0815 1939 Washington.DC Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9001 Cherry Lane 20708 United States permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lundie Earl Castle Thelma Sprinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4013 Lawrence Street Isabelle L. Castle/ Wife Colmar Manor, MD 20722 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Dother (Specify) Ft. Lincoln Cemetery 05/03/2010 Brentwood, MD fun al Service Lin une 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
over I month Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypotension Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Day Pregnant at time of death signed by the a Id be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vascular Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available 24a, Was an certificate has autopsy performed? Yes 2X No prior to completion of cause of death? 1 ☐ Yes 2X No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Tes 2 🔀 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No. 5 Pending s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month. Dav. Year) D24721 04/29/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq, MD 14333 Laurel Bowie Road Suite 208 Laurel, MD 20708 31. Date filed (Month, Day, Year 32. Registrar's Signature State MAY 0 4 2010 Registrar

DHMH 17 Rev 7/2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 2:20 A M DORCAS P. V. CHESNEY APRIL 28 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1□ M 2□ F 88 Director 25 1921 078-62-4352 SEPT. GUYANA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the medical Examinating in a the natified at Director N Yes 2 No MD PRINCE GEORGE'S BOWIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1118 DELCASTLE COURT 20721 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 27√2 No Specify \$ BLACK Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2YRS TEACHER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ABEL Α. CHESNEY LYDIA THOMPSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEYLAND M. LUCAS/SON 1118 DELCASTLE COURT BOWIE, MARYLAND 20721 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/6/2010 EVERGREEN CEMETERY BROOKLYN, NEW YORK 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner elol, Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and Due to (or as a consequ burial physician the burial Box 68760. Physician/Medical as attending poly IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl autopsy Hospital or Attending Physician: The 1 □Yes 2 No Division of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 □ Accident 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in death. 1 □Yes 2 □ No investigation Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jame ras INCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink Figure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1 Physician/ Medical cility Name (if not institution, give street and number) Examiner County of Death Carro 11 4b. City, Town, or Location of Death thinste Age (In yrs last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min. Country) Director Cuba Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 Yes 2 No 11c 10e. Street and Numbe ö 10f. Zip Code ems 23a or r must be i 10g. Citizen of What Country's Funeral United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar most 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Force þ 1 X Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Cuban Other Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Úkn Ukn Ukn Ukn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Antonia Cardenas Jose Cardenas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guardian <u>Kim Viti Fiorentino,</u> 2505 Park Potomac Ave. Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State FT. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 5/4/2010 Signature of Funeral Service Licensee M01463 Simple Tribute 22. Name and Address of Facility 1040 Rockville Pike, Rockville, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or learlifailure. List only one cause uneach line. 23a. Part 1. Interval Between Immediate Cause (Final Onset and Death Physician/ aRni disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 No cate has been signed by the a page 2 should be detached in 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Completed by √ ☐ Yes 2 100 3 Probably 4 Unknown this certificate has been . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 욘 Other: 1 ☐ Inpatient 2 ☐ FR/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 🗌 Yes Accident 2 🗌 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar's Sign Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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	or deg	ne l	11. Marital Status	12. Was Decede Armed Force	nt Ever in U,S.	13. Wa	as Decedent of H	lispanic Origin? (San, Mexican, Pue	Specify Yes or N		ce - America		
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Jar	2 sho		19a. Informant's Name/Relations		or Rural Route Number, City or Town, State, Zip Code) Chevy Chase, MD 20815								
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Baltimore,	8 = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removel from Stat	le l		ion (Name of tory or other plac	1	Date	20c. Location	- City or Tow	n, State	
Ħ	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (S	pecify)	Smit		g Cremat		5-12-20	10 Smit	hsbur	g, MD	
Ba	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J												
		12323 Bladbury Ave.									MD ZI	783	
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each	ed the death. D	o not enter t	the mode of dyin	g, such es cardia	c or respiratory	arrest,		Approximate Intervel Between Onset end Death	
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<u>Р</u> .	the d	ysi	Part II. Other significant conditio	ns contributing to death	but not resulting	g in the unde	erlying cause give	en in Part I.	23b. Did	tobacco use co	ntribute to t	the cause of death?	
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g	n sign	d by	MITMS  ADENCE  25. Was case referred to medical	2					24a. Was	an autopsy	24b. Wer	e autopsy findings	
Division of Vital Records,	w require been si should I	Completed	MITAR	- /LEGU!	261779	70M	/		perf	omed?	com	lable prior to pletion of cause	
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	pltal ours a erai D	29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or										ed. ne cause(s)		
	To th Within To th comp	×	29b. Signature and title of certifier		()		29c. License	number		29d. Date signe	d (Month, Da	ay, Year)	
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•			30. Neme and address of person v				nt)			- 1			
			Dr. Vincent A.	DiPietro, 7	801 Yor	k Road	d, Balti	more, M	21204				
	Stat Registra	.~	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	A A	Son Pel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GEORGIA LEE Month CHANEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WESTERN MD REGIONAL MEDICAL CENTER **CUMBERLAND** ALLEGANY If Under 1 Year If Under 24 Hrs. Funeral Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) WEST VIRGINIA 8. Date of Birth 1 □ M 2 🗓 F Months Days Hours Min (Month, Day, Year) 1/10/1930 Director 236-50-0510 79 Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD ALLEGANY **CUMBERLAND** 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 143 POLK STREET, APT. A-1 21502 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COOK & WAITRESS RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ALBERT WHITACRE DESSIE YOKUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERESA GROWDEN / DAUGHTER 450 BELDEN ROAD, BEDFORD, PA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Spegify) CUMBERLAND CREMATORY 01/06/2010 CUMBERLAND, MD 21. Signature of Funeral Savin Lidense 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ RUPTURED ABDOMINAL ADRTIC ANEURISM Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant 9 ☐ Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier ည 29c. License number Hardin 26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sh Rd. Cumberland, MD 21502 Sidhu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Ida Catherine <u>11:</u>55₽<sup>™</sup> Cook April /Medical 2010 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Homestead Manor Denton Caroline 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 □xF Director 220-05-1931 89 November 19,1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 Ves 2 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a 209 Maple Avenue 21660 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s Funeral United States of America
No- 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 X Widowed 4 ☐ Divorced Caucasian Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home *11* HS Grad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Haze1 Callaway Lu1a Victoria Mandrel1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau
once. Kennard L. Cook Son 211 Sunrise Avenue, Ridgely, Maryland 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ridgely Cemetery 5/1/2010 | Ridgely, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 50 12 South Second St., Denton, Maryland 23a. Part1. Enter the disease, our omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician dilated Cardionvoda /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached i 9□Unknown 9 ☐ Unknown cate has been signed I page 2 should be deto Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural death, 1 ☐ Yes 2 ☐ No 2 Accident the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 00053922 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melinda Butter 136 Lednum An aw 21655 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 3 0 2010 Registrar

153

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1 38 bora sho U Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death MARYLA Dow them 0 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 1 □ M 2 🔏 F Months Days Hours Min. Director 437-20-1634 ouis Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** 10d. Inside City Limits 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2074 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💆 No Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give 3 Nidowed 4 □ Divorced Specify: Blade Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) 12 Socia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 wold 20774 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 5 Other (Specify) 4 Donation -2-10 21. Signature of Juneral Service License 22. Name and Address of Facility w 2080B Tune 121 23a. Part 1. Enter the disease, or complicating is that caused the death. Do no, enter the minde of dying, such as cardiac or respiratory arrist, see health achiline. Approximate shock, or heart failure. List only one ca nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or illijury Examine Due to (or as consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death Month Day Year To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 1 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No Yes 1 🗌 Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 12 No Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No after death Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the I only one 29b. Signati e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tem\_23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. Req strar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Ochn 2:150 10 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Plata 6. Sex 10 M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 90 Director 213-22-2197 Maryland Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No Marzyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20646 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 MYes 2 No 195 If Yes, Give Year or Dates: 1953 1 ☐ Never Married 2 Married 2 No 1951 Baltimore, Maryland 21215-0036 'natural", or 1 ☐Yes 2 ☐No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Back Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ruell 2001 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 ennis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i regnnette 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee Fart 1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕜 No 3 ☐ Probably 4 🗍 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 □ Yes 2 🗌 No within 24 hours after death To the Funeral Director; 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

BION

31. Date filed (Month, Day, Year) MAY 0 4 2010

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

Registrar

20646

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ewell Cox 1025 2001 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL SOLISKINI NIOMIO TENINSULA 8. Date of Birth
(Month, Day Year) If Under 1 Year | If Under 24 Hrs 6. Sex Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Months Davs Hours Min Maryland Director 79 1930 218-24-5723 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MDDorchester Cambridge 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 740 Foxtail Dr. Apt. 320 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Baltimore, Maryland 21215-0036 δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White Completed 3 ▼ Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Injury or other traumatic event injury or other event injury or other receptionist hair salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laurence Ewell Mildred Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Lewis daughter 401 Sandy Hill Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State East New Market Cem. 5/3/10 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYDOOTDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confined to the Funeral Director. the attending physician and ned for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer (Month, Day, Year) Natural 5 Pending Accident М 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D40715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar MILKING ST.

M.O.

106

Registrar's Signat

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Eleanor Cunningham 0600 M 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death S DU CU If Under 24 Hrs Min. Social Security Number 6. Sex 7. Age (In yrs. last drithday) comico 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Y July 28, Year) 91<u>7</u> 1 □ M 2 🛛 F Months Days 92 151-01-7218 Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Wicomico Sharptown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21861 USA 404 Joe Morgan Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Cooper Thomas Henry Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 95, Sharptown, Maryland 21861 Geraldine M. Parsels 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify St. Mary's Cemetery 5/7/2010 Bellmawr, New Jersey 21. Signature of Euneral Service Li 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802

Approximate Interval Between Onset and Death

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Department of Health a Important: If Item 27 is any injury or other trauonce.

**Physician** 

Examiner

10a. State

Directo

Funeral

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Completed

Be

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Immediate Cause (Final

**Funeral** 

Director

, or items 23a or 28a-f show

traumatic event, the Wadical Evanings must be notified at

"naturai",

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

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/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician for use as the burial certificate has trector, page 2 s

Division of Vital Records, P.O. Box 68760,

dical Examiner	disease or condition resulting in death)  Sour flow list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	en year				
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ě	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
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ation:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accidentinvestigation	28a. Date of Injury (Month, Day, Year)  28b. Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred			
Cermin	3 Suicide 6 Could not be determined	Ref. Location (Street and Number or Rural Route Number, City or Town, State)				
Icai	(Check only 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner state.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)			

Part I. Enter the disease, c complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one are on each line.

State Registrar

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID.

William H. Robins.

(Month, Day,

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	State Registrar			Cer	tificate of	Death			Reg. No	201	0	1546
an/	Decedent's Name (First, Middle,							2. Date of De	eath Da	av `	rear	3. Time of Dea
ical	Lois P.  4a. Facility Name (if not institution,	Dressler	orl .		4b. City, Town, o	au Lagatica	of Dooth	April		2010		5:20 P
ner	Hill Haven Nur		1)			elphi	of Death		40	. County of		
		6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Year	If Under		8. Date of Bi			9. Birthp	eorge's
	017-16-4017	1 🗆 M 2 🔀 F	95	Yrs.	Months Days	Hours	Min.	May 3	* 191	4 1	lass.	achusett
5	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	cation						1	0d. Inside City Li
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ā	10e. Street and Number	O.M.O.L. y			10f. Zip Code				10g. Cit	tizen of Wh	at Coun	itry?
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10 B	17. Father's Name (First, Middle, La							e (First, Middle	, Maiden	Surname)		
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	21. Sign sture of Funeral Service Li	ensee		GO	Name and Addre	ess of Facili	atio	n Servi	ce P	P.O. F	30x '	784
	Juanta K	Momas		957 JBE	verly L.	_неск	rott	e, P.A.	. CIa	rksvi	lle	, MD 210
	23a. Part 1 Enter the disease, or of shock or heart failure. List or Immediate Cause (Final	complications that cau nly one cause on each	sed the death	n. Do not ente					rrest.			Approximate
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DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ Day Margaret Arlene DELLINGER 0015 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Washington County Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 8. Date of Birth Feb. 10 1 🗆 M 2 🔀 F Hours <sup>'ear)</sup>1920 213-18-8658 90 Maryland Director Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The treath and Mental Hygiene. The treath and Mental Hygiene of the treath and the treath and the death and the content treatmentic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20014 Rosebank Way 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) bookkeeper auto sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Sayles, Sr. Ruth Tetlow 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code)
1001 E. McKinley St., Chambersburg, Pa. 17201 Anita Buchanan - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Lawn Mem. Park 5/7/10 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME W (415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-1 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atten for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ned by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed of 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? this certificate 2 🗌 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ျ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work nours after death.

neral Director: Aft 1 Yes 2 No ☐ Accident☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check To the P within 24 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 5

3H-6 State

Box 68760

P.O.

of Vital

Division

Registrar

11110 Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HigginbothanND

3

31. Date filed (Month, Day.

20055

Rd. Hügerstain

			Please Type or Print in Black Inc		_
			_ FOI	artment of Health and Mental Hy rtificate of Death	giene 2 0   0   5   7   Reg. No.
	Dhysisi	<b>^</b>	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year
	Physici /Medic		Casimir Bannell Dlugosz	May	2 2010   12:05 P <sup>M</sup>
4.	Examin	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Loyalton of Hagerstown  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown	Washington County  9. Birthplace (State or Foreign
	Funeral		5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   143−16−2011   1	Months Days Hours Min. 8. Date of Bir (Month, Days June 30	y, Year) New Jersey
	Director		Usual Residence of Decedent	pulle 30	New Jersey
	yland yland		10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
	Mar a-f st	ctor	Maryland   Washington County   Hagerstow	<i>n</i> n	1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, its Medical Exaction or must be rediffed at	ral	13718 Royal Rd.	21742	U.S.A.
	, or items ?	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by F	1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 1 Never 1943-1945	1 □Yes 2ሺNo <i>Specify:</i>	Specify: White
ခု	hour tural	ed	15 Decedent's Education 16a, Decedent	dent's Usual Occupation	16b. Kind of Business/Industry
15	in 72 n "na nedic	plet	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	
212	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Machin	ne Repair Supervisor	Truck Mfg.
b	be filed valued by the half Hygid of the event, in	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
/lai	should be f and Mental I s marked oi umatic eve	2	Casimir Dlugosz	Victoria Malec	Dlugosz
	- ct 60 ==		1	ng Address (Street and Number or Rural Route Numb	
2	1 and 2 Health a tem 27 i			Pontiac Ave. Frederick, Massississis (Name of Date	1D 21/01 20c. Location - City or Town, State
0	Solo		1 1 ABuriai 2 i Iuremation 3 i i i i i i i i i i i i i i i i i i	natory or other place)	•
tim	it. Pa rtmer rtant njury			cion Cemetery 5-8-2010  Name and Address of Facility Douglas A.	Piscataway, New Jersey
Bal	permit. Page Department Important: If any Injury or once.			.331 Eastern Blvd. North	•
	_			er the mode of Jying, such as cardiac or respiratory a	
			shock, or haft failure. List only one cause on mich line. Immediate Cause (Final	110716 101.1	Interval Between Onset and Death
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7	Examiner		Who I TIDE	ENTENDED AND (U	14
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of Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only	one) ARICARD
of \	ys dir is	ပ္	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		
	fing After funer	ioi	27. Manper of Death  1 Natural 5 □ Pending (Month, Day, Year) 2 IT Arcident investigation	f 28c. Injury at Work? 28d. Describe  M 1 ☐ Yes 2 ☐ No	how injury occurred
Division	Attending in death. ector: After by the fune.	ficat	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, str		(Street and Number or Rural Route Number,
5	after after Direct of in b	Certification:	4 Homicide determined building, etc. (Specify)	City or To	wn, State)
	Hospital		29a. Certifier (Check only, Check		
	the the	Medical	one) and manner stated.		29d. Date signed (Month, Day, Year)
_	on con	-	29b. Signature and the other titlet	29c. License number	CICION DATE SIGNED (IMPIRIT, Day, Teal)
7			30. Name and address of erson who con pleted cause of death (Item 23a) (Type,	Print) ()	3/4/6010
8	H 9+1		THEY E- METALA UD 13475	Flathe STETOI H	Howsteen, Mit 21792
3	Sta	ate	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature		
	Registi	rar	MAY 0 5 2010		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LAURIE ELIZABETH DUNLAP APRIL 2010 3:02 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country 1 M 2 K Months Days Hours March 23, 1951 215-50-3472 Yrs **Director** 59 Usual Residence of Decedent 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Tes 2 No MD North Potomac 10e. Street and Numbe 6 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11208 Joshua Tree Place 20878 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. ŗ, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify White "natural" 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Market
000ce. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Entreprenuer Theater/Producer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Dunlap Edith Elizabeth Milks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Dunlap Wolcott, Siste 5107 Yosemite Dr., Rockville. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 K Cremation 3 ☐ Removal from State Ft.Lincoln Crematory | 5/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) ATTHIOSAICCMA Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No for Pregnant at time of death 5 Other (specify) Month Day Year 1 Pes 2 Dunknown detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 💢 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and on involving the course of the basis of examination and on involving the course of the basis of examination and on the course of the basis of examination and on the course of the basis of examination and on the course of the course of the basis of examination and on the course of the c 29b. Signature and title of certifier VA 0101238841 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MD 20892 Lynn Halmes

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Ma	aryland /		rtment of He dificate of De			_	211111	15473
Physician	2/	Decedent's Name (First, Middle, Last)	4.3				2. Date of De Month	Reg. No		3. Time of Death
Physiciar Medica	al	Hattie Corine Dav	1 <b>a</b>		# 0': T		April	26,	2010	12:55 A. <sup>M</sup>
Examine	er	4a. Facility Name (If not institution, give street and number) Washington Adventist Hosp	ital		4b. City, Town, or l. <b>Takoma</b>				County of Death  Montgome	
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last bii		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 1	938 g. Birth	place (State or Foreign
Director	ŀ	239-54-7026 The Parish	12	Yrs.			Februa	ry 1	3,  Nort	h Carolina
yland f shor	cto	10a. State 10b. County	10c. City, Tov							10d. Inside City Limits
r 28a- notifi	Director	District of Columbia  10e. Street and Number	, v	Washi	Ington 10f. Zip Code			10a Ci	itizen of What Cour	1 X Yes 2 □ No
with the s 23a c ust be	Funeral	1814 Irving Street, N. E			2001	8		-	ited Stat	
0 19	<u>۾</u>	11. Marital Status  1 IX Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent E Armed Forces?  1 ☐ Yes 2 X If Yes, Give Year or Dates,	pecify Yes or No- o Rican, etc.)		14. Race - Americ Black, White, Specify: <b>B1</b> a	etc.				
5-0	plete	15. Decedent's Education (Specify only highest grade completed)	16	a. Decede	ent's Usual Occupat and of work done du	tion uring most of wo	rking	16b. K	Kind of Business In	dustry
21215-0036 within 72 hours after giene. ier than "natural", o t, the Medical Exam	Completed	Bementary/Seconday (0-12) College (1-4 or 5 <b>9th grade</b>	+)	life. DO	NOT use retired) nestic Wo:				Domestic	
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Maryland 12 should be filed tith and Mental Hy 27 is marked oth r traumatic even	욘	(unknown)				Rose		vid		
Ma 12 sho atth and 27 is i		19a. Informant's Name/Relationship (Type, Print) (Son Warren Donnell Scarborough		-	Address (Street and Mater Fe					Code) 1and 20774
Baltimore,  bermit. Page 1 and Department of Hea Important: If item any injury or other	1	20a. Method of Disposition  1 🛣 Burial 2 🗆 Cremation 3 🗀 Removal from State	20b. Place	of Dispos	ition (Name of atory or other place,	1			ocation - City or To	
ti. Page tment tment rtant: I		4 ☐ Denation 5 ☐ Other (Specify)	1	Line	coln Ceme	tery 2	010		entwood,M	
Bal permi Depar Impol any ir		21 Signature of Funeral Service Liversee	1							orticians, on,D.C.20011
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  a	steen	nd	the mode of dying,	, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Chset and Death
7 60 cate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a Due to (or a) Due			on fred	~ ya	<i>^</i>			Schenkuer
760 cate be	edical	d								
68 entif	Σ۱	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  IF FEMALE: 23c. If yes, outcome 1 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)				23d. Date of deliv Month	rery Day Year
ds, P.O quires that then signed by	ক্র	Part II. Other significant conditions contributing to death be	it not resulting	g in the un	derlying cause give	n in Part I.				he cause of death? bably 4 Unknown
Division of Vital Records, P.O. Box lal or Attending Physician: The law requires that the death or after death.  12 Director: After this certificate has been signed by the attented in by the funeral director, page 2 should be detached for unit by the funeral director, page 2.	Completed	OF Was some sets and to read that					1 Tes	osy ormed?	prior to co death?	opsy findings available ompletion of cause of
Vita vsiciar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: Inpatie	nt 2	Outpatient	Other	ce of Death (Che		dence f	6 ☐ Other (Specify	vi
on of ending Ph eath. or: After thi he funeral		27. Manner of Dea n  17. Natural 5 Pending 2. Accident Investigation  28a. Date of injur (Month, Day	y 28b.	. Time of injury	28c. Injury a work?	at	28d. Describe			
ivisi	Certi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc		farm, stree	et, factory, office		28f. Location (\$ City or Tox		nd Number or Rura e)	l Route Number,
e Hospital n 24 hours e Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of examiner: On the basis of examiner and the best of the best of examiner on the best of examiner of the best of examiner. To the best of the b	amination and/	l/or investig	gation, in my opinion	, death occurred	at the time, date a	and place	e, and due to the ca	use(s) and manner stated.
To the within to comp	- 1	29b. Signature and title of certifier	~ 1/2		29c, License r	number 1889	5		ate signed (Month,	
		30. Name and address of person who completed cause of de Mi BARAK HAMUM TOLD C	ath (Item 23a)	Type, Pr	int) Sut T	3401 To	Kon J	ant	1 per D	200
State Registra		31. Date filed (Month, Day, Year) 32. Registra  HAY 0 3 2010	's Signature	Ke						

Please Type or Print in Black Indelible Inko Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 1:25 P M 201'Ö 25, DAVID ROY DARNELL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CUMBERLAND ALLEGANY 513 FORESTER AVENUE f Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, ) SEPT. I, 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year Months Days Hours Min. X M 2 F MARYLAND 217-34-0103 1938 Director 71 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene. ant. If lies Z1 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Im Medical Eventual to nother braumatic event, Im Medical Eventual to nother traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD CUMBERLAND ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 FORESTER AVENUE 21502 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12€ Yes 2 No 1957 -13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify WHITE Completed by Specify: 3 Widowed 4 Divorced 1963 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **ENGINEER** RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ ROY W. DARNELL ESTELLE (GILL) DARNELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEANETTE (CARTER) DARNELL WIFE 513 FORESTER AVENUE, CUMBERLAND, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) APR 28 2010 CUMBERLAND, MD HILLCREST MEM PARK 22. Name and Address of Facility HAFER FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licenses 1302 NATIONAL HWY., LAVALE, MD 23a. Part I. Enter the disease, or complications/that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 6 months disease or condition resulting in death) /Medical Due to fer as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð icate has been significate page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \( \square\) No 1 ☐Yes 2 ☐ No 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident the 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and title of certifier 9318. APRIL 26, 2010 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) Comperfeed Mel 21502 "Furist ten 6/d Town 31. Date filed (Month, Day, 32. Registrar's Signature Year)

SY'S

DHMH 17 Rev 1/2001

Registrar

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Month Day 1:43 P M Irene Elizabeth Drummond May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline 10269 Bridge Street Denton 8. Date of Birth (Month, Day, Year) August 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Min. Days 1 □ M 2 □ F Months Hours 213-22-9633 Maryland 81 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □ No Maryland Caroline Denton 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21629 United States of America 10269 Bridge Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 11 HS Grad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Clarence Seth, Sr. Emma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Thomas Drummond 1614 Lexington Avenue, Cape Girardeau, Missouri 63701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

State Registrar James Sides,

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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**Funeral** 

Director

should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 28a or, 28a-f show any injury or other traumatic event, the disciplinate Enumeration and injury or other traumatic event, the disciplinate Enumeration and injury or other traumatic event, the disciplinate Enumeration and injury or other traumatic event, the disciplination and injury or other traumatic events.

burial-trar the attending physician hed for use as the buria signed by t page 2 should has certificate this within 24 hours after death.

To the Funeral Director: After the filled in by

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

4 ☐ Donation 5 ☐ Other (Specify)	Spring	Grove Cemetery 5	VIIVIO   D	enton, Maryland
21. Signature of Funeral Service License		22. Name and Address of Facility	loore Funera	1 Home, P.A.
Kaulsski	noun			on, Maryland 21629
23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not each line.	enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Aprilic	Stenos	15	Very
resulting in deathly	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
d.				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions conf	ributing to death but not resulting in the	e underlying cause given in Part I.		use contribute to the cause of death?
Hyperte	vojov		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of D	eath (Check only one)	
Till tes 212110	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Mann of Death 1 atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injur	of 28c. Injury at	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, de er: On the basis of examination and/o and manner stated.	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ice, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	17 (	29c. License number	29d. D	ate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Denton, Maryland

21629

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

920/Market Street

M.D.,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 30, 2010 Betty Louise Dodson P M 9:15 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours 79 214-28-1657 Maryland Director Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Examiner must be profitted at once. Director 1 X Yes 2 □ No Maryland Dorchester Secretary 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 South Street 21664 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Manufacturing Wire Weaver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Matilda Scharph Oscar Thomas Lyons ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freddie Dodson/Husband P. O. Box 1, Secretary, Maryland 21664 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐Other (Specify) 5/4/2010 East New Market Cemetery East New Market, MD 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
East New Market, MD 21631 of Furieral Service Li consee 21. Signatur Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5+0 Domertic **Physician** End /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Exami burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1∐Yes 2. No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital hours after death. death.

Baltimore, Maryland 21215-0036

within 24 hours a completely

State Registrar

29b. Signature and title of certifier

12 47924

ST CAMBRIDGE MD 21613

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN

503 BYRN THANWY

31. Date filed (Month, Day, Year)

determined

4 Homicide

(Check only one)

29a. Certifier

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 54/5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month 07:20AM <u>Bernard Marlon Engleberg</u> 2010 pril Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heberew Home of Greater Washington Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖳 M 2 🗆 F Months Days Hours Min (Month, Day, Year) <u>9</u>0 Yrs. **Director** 359-05-1823 1919 <u>Illinois</u> Usual Residence of Decedent , ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Bethesda 1 Yes 2 XNo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7420 Westlake Terrace #1208 20817 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Court Reporter Government Contractor marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be filed f Health and Mental H Item 27 is marked of 2 David Engleberg Tillie Cutler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4997 Starak Lane, Ann Arbor, MI 48105 sortant: If item 2, injury or other t N. Cary Engleberg, Son 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 5/5/10 Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee M01463 1040 Rockville Pike, Rockville, 23a. Part 1. 50 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart rejuve. List only one cause on each line.

Immediate Cause (Final Renal Failure Approximate Interval Between Onset and Death Renal Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 ဳ Unknown Completed Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Mixed Dementia this certificate 2 🗌 No 2 X N or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4x Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After the in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the vithin 2. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200228811 4 28 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Hebrew Home of Greater Home, 6121 Montrose Rd. Rockville, MD 20850 D. Doyle

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

03

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . 2<u>010</u> April Marie Elizabeth Estes 26 2:15 P Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13995 Petzold Drive Waldorf Charles Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Director V<u>irgʻinia</u> 96 578-24-1526 March 914 Usual Residence of Decedent 28a-f show 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 Yes 2XXNo Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 13995 Petzold Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H မှ John Joseph Snider Catherine Lydia Virginia Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i George F. Estes/ Son 13995 Petzold Dr. Waldorf, Maryland 20601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Peter's Cemetery April 30 2010 Waldorf, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ement Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year 1 ☐ Yes 2 ₺ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by signe I be c 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Tyes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) h. .in 24 hou. .se **Funeral Di.c** .a filled in bv determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of crtifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

un Charel 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	ate of Marylar		artment of H <i>tificate of D</i>		, ,	giene Reg. No. 20	10	15480
Ī	Physicia	n/	1. Decedent's Name (First, Middle, Last)			-	·	2. Date of Dea	ith	. Year	3. Time of Death
	Medic Examin	al	Lillian Viol  4a. Facility Name (if not institution, give street)			4h City Town or	Location of Death	Apri1	22, 201		1615 M
	Examin	er	Crofton Rehabilitati				Crofton			e Aru	nde1
	Funeral Director		5. Social Security Number 6. Sex 1 □ M :	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Nov • 12	Year) 926	9. Birthp Count Vi	lace (State or Foreign ry) rginia
	and show at	ō	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Loc	cation				10	Od. Inside City Limits
	Maryla 28a-f Stified	irect	Maryland Prince Ge	orge			Forestv	ille			1 🏿 Yes 2 □ No
	th the 3a or 3 t be n	al D	10e. Street and Number			10f. Zip Code	20747		10g. Citizen of W		
	eath wi	Funeral Director	8008 Steve Drive  11. Marital Status 12. W	as Decedent Ever in U	.S. 13. V	Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-		- America	
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "Latural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1	rmed Forces?  Yes 2 X No Yes, Give ear or Dates.	l II	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		k, White, e B1a	tc.
- - -	72 hou n "natu ledica	Completed	15. Decedent's Education (Specify only highest grade con	n npleted)	(Give I	ent's Usual Occupa	ation uring most of work	ing	16b. Kind of Bu	siness Ind	ustry
717	within giene. er thar the M		Elementary/Seconday (0-12) Co	ollege (1-4 or 5+)	life. Do	NOT use retired) Lab Tech	nician		Gov	ernme	ent
na	ifiled ital Hyged of other event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		-	)	
<u> </u>	should be file and Mental 7 is marked of raumatic eve		John 19a. Informant's Name/Relationship (Type, Pri	D. Kello	10h Mailin	g Address (Street a		Bessie (		toto Zin C	ada)
Σ	d 2 sho alth an alth an 27 is er trau		John D. Joyner/ Son	ŕ		Steve Dri		s <b>tville</b> :		0747	oce)
ore,	je 1 an t of He If item or othe		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Remo		Place of Dispo- cemetery, cren	sition (Name of natory or other place	-1 .	Date 1 29,	20c. Location -	City or Tov	wn, State
<u>=</u>	iit. Pag artmen: ortant: njury e		4 Donation 5 Other (Specify)			rematory	<u> </u>				ryland
Ra	permit. Page 1 and 2 should be fi Department of Heatth and Mental Important: If Item 27 is marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	not III		. Name and Addres 001 Benni	DE		uneral H ington,		Inc. 20019
	hysician Medical Examiner		23a. Fart 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, b. —	ns that caused the dea se on each line.  One of the consecutive to (or as a co	onia		s, such as cardiac o		est,		Approximate Interval Between Onset and Death
00/	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consec							
. Box bg	he death certifi y the attending ched for use a	Physician/M	in the past 12 months?	yes, outcome of pregn Live Birth 2 Fet Pregnant at time of Unknown	tal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Mor	e of delive nth	ry Day Year
s, r.c.	ires that the signed by the deta	d by PI	Part II. Other significant conditions contributed Advance	ting to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	1.0		e cause of death?
or vital Records,	he law requ e has beer age 2 shou	Completed by	Advanced Cor pulmo	nale	•			24a. Was a autop	sy p med? d	Vere autop rior to con eath?	sy findings available inpletion of cause of
<u>a</u>	sian: T ertificat ctor, p	Be C	25. Was case referred to medical examiner?				ce of Death (Check		2 No 1	□ fes	2 🗆 140
<u> </u>	Physic this corral dire	은	1 Yes 2 No	al: 1  Inpatient 2   a. Date of injury	ER/Outpatien	t 3 DOA Othe	4 Nursing Ho		ence 6 Othe		
ouc	nding ath. r: After e fune	icate	1 Natural 5 Pending Investigation	(Month, Day, Year)	injury	work'		zoa. Describe III	ow injury occurre	a	
UNISION	al or Atte s after de: al Directo ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	e. Place of Injury - At h building, etc. (Specit		et, factory, office		28f. Location (S City or Town	treet and Number n, State)	r or Rural I	Route Number,
_	he Hospit in 24 hour he Funera pleted filk	Medical	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or 3 Certifying Nurse Practice.	the basis of examination	on and/or invest	igation, in my opinion	n, death occurred at	the time, date ar	nd place, and due	to the cau	se(s) and manner stated.
	To t with To tl		29b. Signature and title of certifier	20001	mo	29c. License	number 9 5 1	7/	29d. Date signed	(Month, D	20/0
P	-5		30. Name and address of person who completed and address of person	ted cause of death (Iter	m 23a) (Type, P	FDe7	Cense	they	· Cr07	fton	, MO
H	Stat Registra	e ir	31. Date filed (Month, Day, Year) MAY 0 4 2010	32. Registrar's Sign	auto			77			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9.30 AM NZEWOH FOMENKY 26 JOHN /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner HanES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Yrs 51 CAMEROON **Director** 217-04-6276 NOV. 8 1958 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1XYes 2 No Director MONTGOMERY SILVER SPRING MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number CAMEROON 20910 614 SILGO AVENUE # 306 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, Inc. M COMPUTER CONSULTANT PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BEATRICE WILLIAMS JOSEPH N. FOMENKY ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1120 HEARTFIELDS DRIVE SILVER SPRING, MARYLAND 20904 YOLANDA NOKURI HEGNA/SISTER permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trong. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/10/2010 RIVERDALE, MARYLAND RIVERDALE CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CALICNOUN CIRRHO815 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MICHOWN RENAL FAILURE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed LIFE TIME DISEASE SICKLE CELL and burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical P51 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown signed be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an The law autopsy performed? Yes 2 No After this certificate 1 □Yes Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 1√No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division **Hospital or Attending** 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: / 2 Accident 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. within 2 To the

State

JANE

29b. Signature and title of certifier

TAND INDA 300 ARMORT 32. Registra/s Signarire

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATTENDING

Registrar

29c. License number

PLAZE

D00 13948

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29d. Date signed (Month, Day, Year)

APRIL

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2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRTL 30<sup>pay</sup> 2010<sup>ear</sup> PHYLLIS MARIE FREEMAN 3:25A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min APRIL Day Year **Director** 579-38-2404 80 1930 PHIL. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Ty Yes 2 No MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 95 E. WAYNE AVENUE #208 20901 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 NoAIRFORCE Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 Widowed 4X Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH PERSONAL MGMT. SPECIALIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, ဂ္ THOMAS E. MURPHY GERTRUDE SPRIGGS t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRI GREENE/DGT 17443 KAGERA DRIVE DUMFRIES, VIRGINIA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 5/17/2010 RIVERDALE, MARYLAND RIVERDALE CREMATORY 21. Si re of Funeral Ser ice Li ensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) Examiner RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician an eted filled in by the Inneral director, page 2 should be detached for use as the burial-transitied in by the Inneral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical man, Phy 11.5 H/3c/10 62.35 Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ≱ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform 2 💢 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be within 24 hours after de

To the Funeral Directo

completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only on 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D65720 APRIL 30, 2010 30. me and address of person wh npleted cause of death (Item 23a) (Type, Print) 8600 OIX ROSEMARY IWUNZE M.D. GEORGETOWN ROAD BETHESDA, MARYLAND 20814 31. Date filed (Month, Day, Year) 32. Registrer's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 10, 2010 **Physician** MAURICE EUGENE FOSTER 1335 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CALVERT MEMORIAL HOSPITAL CALVERT PRINCE FREDERICK Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral Days Hours Months Min. 577-38-6031 86 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show pical Examiner must be notified at N.C. MACON FRANKLIN 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 226 CASTLEBERRY LANE 28734 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? NETYES 2 □ No ARMY IFYES, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: WHITE Specify 2 3 Widowed 4 Divorced er than "nature , the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DEPT. OF DEFENSE Elementary/Secondary (0-12) 12th College (1-4or 5+) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, Inc. M. U.S.GOVT. ITEM MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAURICE PHIFER FOSTER MARY AMANDA BOBBITT ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 CASTLEBERRY LANE FRANKLIN, N.C. 28734 WILLA M.FOSTER-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. Malpore 2 Cremation 3 Removal from State | Crematory or other place) | 5 Other (Specify) | TRINITY MEM.GARDENS | 5-13-2010 | WALDORF, MD. 21. Signature of Funeral Service Licenses M00479 RATMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Mic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 ButL Physician /Medical Due to (or as a consequence of) Examiner F9: 12113 とうていり ONE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by been signe should be 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b Were autopsy findings available prior to completion of cause of death? has page 2 autopsy certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **₩**No 1 🗌 Yes 1, Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manuar of Death within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31 Date filed (Month Day Year)

Prince, Frederick, MD 20078

ho completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

100 Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month April James Dale Fitez Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min *^372271*928 Director 219-20-4019 82 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No Frederick Brunswick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21716 601 East Η Street USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ▼ Widowed 4 □ Divorced Specify: White Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Police Dept. Of Energy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Henry Fitez Lela Louise Carty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Nuse, Gum Sprind Rd. Daughter Brunswick MD 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State St. Marks Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5/3/2010 Petersville MD Signature of Funeral Service Licensee 22. Name and Address of Facility Awara John T Williams Funeral Home, Brunswick MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Preumonia Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of **E**xaminer JY DAYS Multi ora Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence equires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical الكثر Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 9 Unknown ed by the a detached f 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law After this certif cate has performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral directo, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Suicide 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29c. License number 28,2010 anni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi TREDERICK DOWALD 400 LL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nevis T. Garriques Month Medical April 2010 5:03 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health & Rehabilitation Glen Burnie Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) July 17,1915 9. Birthplace (State or Foreign Hours Min. Director 94 220-03-6856 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7575 E. Howard Road 21060 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify. White Completed 3 Widowed 4 X Divorced Specify Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nanny Children Caregiving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Zolly Palmer Marie Dietrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna LaBarre / Daughter 1015 7th Street Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If its any injury or ot 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 28, 4 Denation 5 Other (Specify) Glen Burnie, MD Sonati re of Funeral Service Livens Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 P.A. Severna Park Funeral Home rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shoo, or heart failure. List only o Im edia e Cause (Final Ph\_sician/ disease r condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown icate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work 1 🗌 Yes Accident 2 🗌 No after death Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physi n: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated ☐ Medical Exami a: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 ☐ Certifying Nurs, Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the within 2 **To the** I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

nth, Day,

Year)

APR 2 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GONZON RANCIS 0749AM 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIVI OF MARYLAND MED CNTR GUTTMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months AUG 17. 221-22-4504 1936 73 Delaware Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Delaware 1 ☐ Yes 2 🕅 No New Castle New Castle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 South DuPont Highway 19720 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Master Sergeant National Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Gonzon Margaret Cimino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Gonzon/Daughter DuPont Highway, New Castle, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State May 4,

Physician/ Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

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	21. Sign Ture of Funeral Service Licer	22. Name and Address of Facility Hicks Home for Fu 103 W. Stockton S	nerals P A
	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not enter the mode of dying, such as cardine cause on each line.  a. SUBDURAL HEMORRHAGE	ac or respiratory arrest, Approximate Interval Between Onset and Death
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  Due to (or as a consequence of):	Q2 DAYS  OVED BY MEDICAL EXAMINER
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)  9  Unknown	23d. Date of delivery  Month Day Year
pleted by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I. $$	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
E 05			autopsy prior to completion of cause of death?  1 □ Yes 2 No 1 □ Yes 2 No
e e	25. Was case referred to medical examiner?	26. Place of Death (Cr	eck only one)
2	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
9	27. Manner of Death	286. Injury 28b. Time of 28c. Injury at	28d. Describe how injury occurred
2	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	1 04-07-2010 6:15 AM 1 1 Yes 2 X No	FALL INTO COUNTERTOP
Medical Certificate:	4  Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1002 Flemming Street Key West, FL
Medic	(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occurre se Practioner: To the best of my line alongs. See the occurred at the line, Jato and p	and due to the cause(s) an manner as stated.
	29b. Signature and title of certifier	29c. License number P2444	29d. Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  04 - 30 - 2010
	30. Name and address of person who TRACY TIMM (	completed cause of death (Item 23a) (Type, Print)  WS MD 22. S. GREENE ST	BACTEMORE MD 21201

State

Registrar

nth, Day, Year

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	State of Maryland / Department of Health and Mental Hygiene	di-di-

			State Registrar			Cer	tificate d	of D	eath			Reg. No	o.			
	Physicia	ın/	1. Decedent's Name (First, Middle, La	est)							2. Date of De	ath			3. Time of Death	
	Medi		Babao Ge								May 3	20°	10 Yea	r	6:45P M	Λ
	Examir	er	4a. Facility Name (if not institution, giv	e street and numb	er)		4b. City, Tov	vn, or l	Location of	f Death		4c	. County of De	eath		
			Gilchrist Hospid					WSC				1	Baltimo	re		
	Funeral		5. Social Security Number 6. S	Sex 7 I□M2 DxF	. Age (In yrs. la		If Under 1 \ Months D	ear ays	If Under 2 Hours	24 Hrs. 8 Min.	B. Date of Bir (Month, Da	v Year)		Birthplac Cou <i>ntry</i> )	e (State or Foreign	n
	Director		212-43-6833 Usual Residence of Decedent		87	Yrs.					April	4,19	923	-	China	
	ind show at	5	10a. State 10b. County		10c. City	, Town or Lo	cation							10d	Inside City Limits	
	anyla ta-f s ified	ect	Maryland Howard	<b>3</b>										100.	1 ☐ Yes 2 😿 No	
	or 28	늅	Mary Land Howard  10e. Street and Number	1		Laur	10f. Zip Co	de				10a Ci	tizen of What	Countral		_
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral Director	10118 Highridge I	Road			· ·	072	7				nited S	,		
	death v items ner mu	٦	11. Marital Status	12. Was Decede			Vas Decedent	of His	panic Origi	in? (Specif	y Yes or No-		14. Race - An			_
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Maryland 21215-0036	2 sho th and 7 is u	2	19a. Informant's Name/Relationship (										Town, State, 2			
	and Healt		Zhengwei Yu/grand 20a. Method of Disposition	ison	Look B				River				Maryla			
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			23a. Par . Enter the disease, or com	plications that as		<u> </u>	verry .	<u> </u>	TIECVI	.ULLE	· F.A.	CTC	<u>rksvil</u>	ie,	MD 21029	<u>}</u>
	33		shock, or heart failure. List only o	ne cause on each	line.	. Do not ente	i the mode of	ayırıg,	Such as Ca	ardiac or re	spiratory arr	est,		Int	proximate erval Between	
æ	Physician/ Medical	1	disease or condition resulting in death)		shic		~								set and Death とんろ	_
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Box	death le att	sici	in the past 12.months? 1  Yes 2  No		nt at time of de		Other (specif)						Month	Day	/ Year	
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Division of Vital Records,	ing P	Certificate:	27. Manner of Death 1	28a. Date of (Month,	injury 2 <i>Day, Year)</i> 2	28b. Time of injury	l v	njury a vork?		- 1	. Describe h	ow injury	occurred			
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ĭ	or Al	동	4 Homicide determined	28e. Place of	Injury - At horr etc. (Specify)	ne, farm, stre	et, factory, offi	ce		28f.	Location (S: City or Town		Number or R	ural Rou	te Number,	
	pital Durs a eral [		20a Cartifica 1 Cartifican Phys	sicione To the best		d - d - d	1.14									4
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 \(\sum \) Medical Exami	ner: On the best	of examination a	and/or investi	nation, in my or	noinion	death occu	irred at the	time date ar	nd place	and due to the	caucole	) and manner state	₃d.
	To the within 2 To the comple		only one) 3 A Certifying Nurs 29b. Signature and title of certifier)	e Practioner: 10	the best of my i	knowleage, as	29c. Lice			nd place, a			and manner a e signed (Mon		Vacel	$\dashv$
			Day & S. J	GRNP					9190	(	- 1		4 4, 2		, our	
		}	30. Name and address of person who co		of death (Item 9	23a) (Type Pr	int)						7 11 2	-10		$\dashv$
	3		Marian Grant	6701	N. Ch	wles 9	IL TOI	ى ي	on V	DN	2120	4				
	Stat	e	31. Date filed (Month, Pay, Year) 5 2	32. Regi	strar's Signatu	re ,					<u> </u>					$\dashv$
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anjia 7:00 A M Douwsma Glenn May ŽÕ10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. July 22 Director 143-32-8551 68 Panama Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2X No Maryland Montgomery Olnev 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 18228 Rolling Meadow Way 20832 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 TNo Specify "natural", Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gerrit Ben Douwsma Ruth Elizabeth Gilson permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Glenn/ husband 18228 Rolling Meadow Way Olney, Maryland 20832 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/4/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 7 M00957 Beverly L. Heckrotte, P.A. Clarksville, 784 • MD 21029 any 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed bunial-transit Congestive Heart Failure and Due to (or as a consequence of) resulting in death) Last Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown 1 Yes 2 2 9 Unknown signed by the a d be detached f Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death. To the Funeral Director: After this control of the Funeral Director: After this control of the funeral Director. Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 No Yes director, Be Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) Hospice 1 Yes 2 **M**Vo ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) May 3, 2010 D60634

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar Bindu Joseph,

31. Date filed (Mon

DHMH 17 Rev 7/2009

Registrar's Signature

6001 Muncaster Mill Road Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Elizabeth Grove 902 A M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b, City, Town, or Location of Death 4c. County of Death University of Mary and Medical Center INID Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 V F Hours Min. 220-18-1032 84 Director Mary Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits MD 1 Yes 2 No Washinaton Williamsport 10e. Street and Number 10g, Citizen of What Country? Funeral Cedar Ridge Road 12409 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 2 should be filed within 72 hours afte th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exar Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th grade nursina home manager tood service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Walter Robinson Cora Mae Hurd 1 and 2 should to the Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bette M. Lee dauahter 13926 Pennsylvania Ave. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-06-2010 Clear Spring, MD Rose Hill Cem. 4 Donation 5 Other (Specify) Little 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc. PC Box 310 Clear Spring, MD 21722 Signature of Funeral Service Licensee 23a. Part 1. En et the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or that failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ inferration Myorardial Medical Examiner 5 days aortic occlusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): years burial-transit Cause (Disease or iinjury that initiated events artery disease Coronan Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Vear Day Pregnant at time of death 1 ☐ Yes ∠ ya g ☐ Unknown the g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by atrial fibrillation, Stroke 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{No} \) No 24a. Was an e Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has is autopsy performed? Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1. Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and #tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 69530533

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

Greene

Bellimore

MD

21201

MD

22.

32. Registrar's Signature

S.

30. Name and address of person why completed cause of death (Item 23a) (Type, Print)

willing

31. Date filed (Month, Day, Year)

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Danielle Gehm		State of Maryland / Department of Health and	d Mental Hyg	jiene	2010	) IFI OF
		1- For State Certificate of Death		Reg	g. No. 4 U 1	7 0470
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death Month	n Day Year	3. Time of Death
Medical Exami	ner	Danielle Gehm	,	April 27, 20	010	0436 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or 1			4c. County of Deat	h
		18610 Sage Way Germantowi			Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth	n(MM/DD/YYYY) 9. Bit Forei	an
Director		343-80-5846 1 M 2 X F 22 Yrs. Says	7 1100.0	FEB. 1,	, 1988 Co	<sup>puntry)</sup> Illinois
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w any		Toda. State Toda. County Toda. City, Town or Location				10d. Inside City Limits  1 Yes 2 No
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hour hatu Exan	pe	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (College (Add on 5))  17b. Decedent's Usual Occupation (College (Add on 5))  17b. Decedent's Education (Specify only highest grade completed)  17b. Decedent's Education (Specify only highest grade completed)  17b. Decedent's Education (Specify only highest grade completed)  17b. Decedent's Education (Specify only highest grade completed)  17b. Decedent's Education (Specify only highest grade completed)			16b. Kind of Business/	Industry
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	To B	John Gehm  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street	Donna Pah.		er. City or Town. State	Zip Code)
☐ st # is if		Alexander Jones, Husband 18610 Sage Wa				, 210 3340)
e, M I and 2 Health item 2'		20a. Method of Disposition 20b. Place of Disposition (Name of cerr			20c. Location - City or	Town, State
OFE OFE Toff		1 XBurial 2 Cremation 3 X Removal from State crematory or other place)	May			
ti Pa		4 Donation 5 Other Specify: Good Hope Cemeter			Greenfield	
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service Licensee  Photography Molecular Molecular Thibadeau 7 Park Ave:	Mortuary	Service	p.a.	7.77
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To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated	death occurred at the	e time, date an	nd place, and due to the	e cause(s)
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神化		()west - o.c.m	Л.E.		April 28, 2010	
	}	30. Name and address of person who completed cause of death (Item 23a)				
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201			
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature August 1997				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State	ite of Maryland /				nd Mental I	Hygieı	ne		
		Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	Death		Reg.	No. 2	0 54	Q
Physic	cian/ dical	Agit Vimor Cunto					2. Date o	f Death . 23, 2	OYON O	3. Time of Dea 9:30	
Exam			nd number)		4b. City, Town, or	Location of [			4c. County of D		
		Montgomery General Hospi			Olney				Montgom		
Funer Directo		5. Social Security Number 6. Sex 1 X M 2	7. Age (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		f Birth , Day, Yea <b>ary</b> 1	g. 1935	Birthplace (State or Fo Country) India	reign
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the N a or 2 be no	٥	10e. Street and Number			10f. Zip Code			10g.	Citizen of What		<u> </u>
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r deat	N. P.	11. Marital Status  1	Decedent Ever in U.S. ed Forces?	13. W	as Decedent of His Yes, specify Cuban	panic Origin , Mexican, P	? (Specify Yes or luerto Rican, etc.)	No-	14. Race - Ai Black, W	merican Indian,	
215-0036 in 72 hours after ie. han "natural", o Medical Exam	d be	3 ☐ Widowed 4 ☐ Divorced If Yea	Yes 2 X No s, Give or Dates.	1	☐ Yes 2 🔀 No	Specify:			Cnoolf //		
5-0 2 hour "natu	plete	15. Decedent's Education (Specify only highest grade comp	16a	Deced	ent's Usual Occupa	tion		, 16b	Kind of Busine	sian Indian	
thin 72	Completed by	Elementary/Seconday (0-12) Coll	ege (1-4 or 5+)	life. DC	ind of work done du NOT use retired) Lcal Engine		working	Т		,	
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DESIGNOFO, IMARYIANG 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	P						Name (First, Mide Bashini				
Mar 2 shou th and th and traum		19a. Informant's Name/Relationship (Type, Print, Kalyani Gupta- Wife	100		Address (Street ar						
of Heal		20a. Method of Disposition	20b. Place of	Dispos	Jacqueline		Date Date		Location - City		
Datimo		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	THOM State		atory or other place, rematory	· :	ril 26, 20	10 G1	len Burnie	e, Maryland	
Depar Depar Impor		21. Signature of Funeral Savuce Ligensee	01234	22.	Name and Address 1eck Funera 601 Sandy	of Facility					
		23a. Part 1. Enter the disease, or complications	that caused the death. Do no	ot enter	601 Sandy Sthe mode of dying,	Spring I such as care	Road, Laure diac or respiratory	e <b>l, M</b> a arrest,	ryland 20	0707 Approximate	
Physician		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	Multilo	ha	s Pn	eun	10 ma			Interval Between Onset and Death	i h
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ie to (or as a onsequence o	101	(				_		
cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c	Demen	tia						1	
cate be executed physician and sthe burial-transit	ä	resulting in death) Last Du	e to (or as a consequence of	f):		_					
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ath certific attending p	J/K	Loo. Vido docodoni progridiri	s, outcome of pregnancy Live Birth 2  Fetal death	• □	=				23d. Date of d	eliven	
Attending Physician: The law requires that the death certific areath.  ector: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as	Physician/M	1 Yes 2 No 4	Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			-	Month	Day Year	
that the dec	by Ph	Part II. Other significant conditions contributing	to death but not resulting in	the und	derlying cause giver	n in Part I.	23e. Did	d tobacco	use contribute	o the cause of death?	,
law requires that has been signed le 2 should be de							_ 1[	☐ Yes 2	2 □ No 3 □	Probably 4 Tunkno	own
law re has be e 2 sh	Completed						24a. Wa	as an topsy	24b. Were a	utopsy findings availat	ble of
ician: The la certificate ha		OF Warrant Control					pe	rformed?	_ death?	es 2 🗆 No	
/sicial	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	M		Othor		check only one)				
ig Phy ter this	te: T	27. Manner of Death 28a. I	Inpatient 2 ER/Out	ne of	28c. Injury a		g Home 5 Re			cify)	
eath. or; Aff	fica	2 Accident Investigation	Month, Day, Year) inj	ury	M 1 ☐ Ye	es 2 🗆 No			,,		
or Att after d Direct in by	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	lace of Injury - At home, farn uilding, etc. (Specify)	n, street	, factory, office		28f. Location City or To	(Street a	nd Number or Ri	ural Route Number,	
ospital hours uneral	Medical	29a. Certifier 1 Certifying Physician: To	he best of my knowledge, de	eath occ	cured at the time, d	ate and place	e, and due to the	cause(s) a	nd manner as si	ated.	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Mec	only one) 3 Certifying Nurse Praction	Dasis of examination and/or i	investio	ation, in my opinion, th occurred at the ti	death occurre me, date and	ad at the time date	and alaa	a and direct attack		stated.
<b>5</b> ≥ <b>6</b> 8		29b. Signature and title of certifier	MD		29c. License ni	umber 0 9 9	9	29d. Da	ate signed (Moni	h, Day, Year)	
Dill.		30. Name and address of person who completed		pe. Prir		_ / /	<u>'</u>	<u></u>	4/2	5/10	
15		18101 Prince Philip	Drive, Olney, Ma			وبمصابرت	11.17.				
Sta Registr			2. Degistrar's Signature								$\neg$
5,50		MI II W D EDIO	com p.	y w	Nam.						

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 29d per phys. G904 6722/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ April 26 2010 6:25p Agnes I. Gillespie Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** College View Nursing Home Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🗆 M 2 🏝 F Min. 73 Months May 18, Year) 36 Mary land Director 217-32-6102 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Frederick Emmitsburg XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 514 E. Main Street USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2**XX**No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Completed 3 Widowed 4CCDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha meat wrapper Food Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ൧ Lawrence Haley Irene Stouter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Cynthia Marshall - daughter Fox Trail, Fairfield, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Stauffer Crematory May3,2010 4 Donation 5 Other (Specify) Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home an 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ \* Theumonia disease or condition ) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 9 Unknown the P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 2 1 🗌 Yes Records, Direase 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Cardio myopathy law r cate has l autopsy Attending Physician: The certificate 2 N Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Certificate: After injury Natural 5 Pending 2 🗆 No n 24 hours after death.

e Funeral Director: A pleted filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier peted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 within 2. To the F only one) 29b. Signature and title of certifier 29c. License number April 27, 2010 6041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen MD 2170) 31. Date filed (Month, Day, Year) shal 32. Registrar's Signature State

Registrar

Please Type of Print in Black Indelible late English And Adord Livring

	1 - State Registrar	yland / Department of Health an  Certificate of Death	Reg. No.  2. Date of Death  3. Time of Death
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Rubert	Grusenmeyer  4b. City, Town, or Location of D	Month Day Year
Examiner Funeral Director		Baltimore City	•
	Usual Residence of Decedent	Oc. City, Town or Location Severna Park	10d. Inside City Limits 1 □ Yes 2 🛣 No
3a or 28a-f sl	10e. Street and Number 137 Evitt Court	10f. Zip-Code 21146	10g. Citizen of What Country? USA
l", or items 23e	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Eve Armed Forces?  1 Never Married 2 Married In Married I	r in U.S. 1944- 1945  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 □ Yes 2 ☒ No Specify:	19 (Specify Yes or No- puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
"natura dical E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most or life. DO NOT use retired)  System Analyst	f working  16b. Kind of Business/Industry  Telephone Company
and Mental Hygiene. is marked other than tumatic event, the Me To Be Comp	17. Father's Name (First, Middle, Last) Michael Grusenmeyer	18. Mother's	s Name (First, Middle, Maiden Surname) rtha Thies
th ar	19a. Informant's Name/Relationship (Type. Print) Gail Grusenmeyer/ wife		or Rural Route Number, City or Town, State, Zip Code) everna Park, MD 21146
Department of Health Important: If item 27 any injury or other tra	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)  Holy Cross Cemetery	20c. Location - City or Town, State 2010 Brook Park, OH
Departra Importa any inju once.	21. Signature of Funeral Service Licensee	Barraned address of sility 495 Gov. Ritchie	P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146
should be detached for use as the burial-transit and should be detached for use as the burial-transit and should be detached by Physician/Medical Examiner	23a. Part Enter the die ase, or complications that caused the shock, or lear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a condition of the cause) Due to (or as a condit	consequence of):	Interval Between Onset and Death
by the attending pletached for use as Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tim 9 □ Unknown	☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
signed by d be detact	Part II. Other significant conditions continuously to death but	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
has ge 2			24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 1 1 Yes 2 1 10
is certificate I director, pa To Be Co	25. Was case referred to medical examiner? 1	Othor:	f Death (Check onlone ing Home 5 ☐ Residence 6 ☐ Other (Specify)
within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.  Medical Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Ye	M 1 ☐ Yes 2 ☐ No - At home, farm, street, factory, office	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)
ithin 24 hours at the Funeral D or the Funeral D or the Funeral D or the Funeral D or the Funeral D or the Funeral Celebrate Section 1 the Funeral Celebrate S	29a. Certifier (check only one)  1 Jertifying Physician: To the best of results of examiner: On the basis of examiner and manner state	kamination and/or investigation, in my opinion, death	place, and due to the cause(s) and manner as stated.  occurred at the time, date and place, and due to the cause(s)
within ; To the comple	29b. Signature and title of certifier  **Regions** Tu	29c. License number	29d. Date signed (Month, Day, Year)  April 24 2010
NAH	30. Name and address of person who completed cause of dea		00 North Wolfe St, Baltimore, MD, 2128

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2000 8:50 Р м Brenda Davey Glennon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV 21 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖵 F Hours New York 117-44-4859 58 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No Maryland Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6529 South Clifton Road 21703 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2XXMarried Yes 2 XXIII Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX lo Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Greenwood Warren Davey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6529 South Clifton Road, Frederick, MD 21703 Mr. Thomas A. Glennon, husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery May 17, 2010 Frederick, MD 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lione. 22. Reeneydand Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final undille Physician concinoma disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death 4 Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstruction 2No 3 Probably 4 Unknown 1 Yes After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
1 Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 X No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours a er dectt To the Funeral Director: / сотрleted filled ibv the i 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Gentifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W '747 St

32, Regi trar's Signature

Anish Desci

31. Date filed (Month, Day, Year)

D67657

Frederick, MO 21701

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 7:05 AM Mae Rita Veronica Garrett May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ceci1 125 Maffitt Street E1kton 8. Date of Birth (Month, Day, 1) Mar • 23 5. Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. Year 1 🗆 M 2 💢 F Director 1915 95 Maryland 217-05-6967 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If feem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🌠 Yes 2 □ No E1kton Maryland Ceci1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 125 Maffitt Street United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) executive secretary Government Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Mary C. Hitchens Issachar W. Garrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Maffitt E1kton, MD 21921 Sr. Isabel Garrett OSF/sister St., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 05-06-2010 1 X Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Conception Cem. Elkton. MD 22. Name and Address of Facility R.T. Foard & Gee 21. Signatur Fineral Service Licenses 259 East Main St. Elkton. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate consequence of Examin cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) burialnding physician are as the burial Physician/Medical that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy in the past 12 months? Day Other (specify) Pregnant at time of death ed by the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 2 7 No 3 Probably 4 Unknown Division of Vital Records, 1 Tes Completed 24a. Was an Were autopsy findings available prior to completion of cause of cate has l page 2 s autopsy death? certificate Yes To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 17 No 1  $\square$  Yes ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Assidence 6 Other (Specify) in 24 hours after deau., the Funeral Director, After this of moleted filled in by the funeral di this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 827 In Cee Ha Mr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month,

Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 5:55 AM Michael Joseph Hahn 010 /Medical  $M\Delta$ 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NONE TIMORE 8. Date of Birth
(Month Day,
June 18, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 56X 14∑M 2□F <sup>Ye</sup>1956 Months Days Hours 220 68 1499 53 MD Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No Howard Ellicott City MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Modical Exeminer must be re-3727 Bonnybridge Place 21043 United States 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stadium Manager Security 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William A. Hahn, Sr. Mary Jane Neser ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet S. Hahn/Wife 3727 Bonnybridge Place Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Crematory 5-4-2010 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** DAYS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate base. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical led by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy 1 ☐ Yes 2 ☐ No 2/ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Hospita! 22 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 □Yes 2 □No within 24 hours after death To the Funeral Director: the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely

HAHN, MICHAEL Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

(Check only one)

31. Date filed (Monta

Registrar's Signatu

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONQ

AGNES HOSPITAL

State Registrar

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examination must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		Registrar 4/20/10 AACO HEA	TITH DEBT. CMH	Certificate of Dea	<i>tn</i> R	eg. No.				
		1. Decedent's Name (First, Middle, Last)			2. Date of Dear		3. Time of Death			
hysici		Eva H. Hebron		April 2	April 26 2010 Year 0515 a M					
/Medic		4a. Facility Name (If not institution, give stree		11						
Examin	ier		,	4b. City, Town, or Locati	on of Death		unty of Death			
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uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Months Dave Hou	der 24 Hrs. 8. Date of Birth rs Min. (Month, Day)		thplace (State or Foreign			
rector		214-26-3035 1DM	85	Yrs.		1925 Ma	rvland			
25		Usual Residence of Decedent			1 1100 1 030	10101110.	- 1			
MO #		10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits			
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28a	Director	Maryland Anne Aru	ndel Gler	n Burnie 10f. Zip Code		0 0 0 0 0 0 0				
ò				Tot. Zip Code	1	ug. Citizen of What Co	g. Citizen of What Country?			
233	Funeral	926 Jay Court		21061		USA				
ems Fu	ne		Vas Decedent Ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes or No-	14. Race - Ame				
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E a .	ð	3 ☐ Widowed 4 ☐ Divorced Y	Yes, Give " ear or Dates:	1 □Yes 2/⊡No Spec	ony:	Specify:	Black			
ig af	Completed	15. Decedent's Education	n 1	6a. Decedent's Usual Occupation		16b. Kind of Business	/Industry			
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tha i	Ē	Elementary/Secondary (0-12) C	College (1-4or 5+)	•		State of	Maryland			
nt, I		17. Father's Name (First, Middle, Last)	0 1	Parole & Proba						
eve d	Be	17. Father's Name (First, Middle, Last)		18. MG	other's Name (First, Middle, I	raiden Surname)				
arke atic	၉	Benjamin Ha	milton		Carolin	e Oueen				
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be rediffed at once.		19a. Informant's Name/Relationship (Type. F		9b. Mailing Address (Street and Nu			Zip Code)			
27 i		Carolyn Hebron (D		926 Jay Ct. G						
the		20a. Method of Disposition	20b Place	of Disposition (Name of		20c. Location - City or				
= 5		1⊠ Burial 2 ☐ Cremation 3 ☐ Remo	val from State ceme	tery, crematory or other place)		EGC. EGCATION - City of	Town, State			
ury land		4 ☐ Donation 5 ☐ Other (Specify)	St.	Rest Cemetery	4/29/10	Hanover,	Md.			
y Por		21. Signature of Funeral Service Licensee		22. Name and Address of Fa	cility					
트 등 등		Farry A, Reese	1100483	Wm. Reese & 821 West St	Sons Mortu	ary, P.A.	21.401			
		23a. Part 1. Enter the disease, or complication	ns that caused the death D	o not enter the mode of dving such	as cardiac or reeniratory arm	mapous, wo				
		Shock, of fleart failure. List only one ca	use on each line.	o not onto the mode of dying, odon	as cardiae or respiratory arre	,50,	Approximate Interval Between Onset and Death			
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tending physician and r use as the burial-transit	n/Medical									
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ping	eq	Coronary It	Tery Dis	ease	1 X Ye	s 2 □ No 3 □ Pr	obably 4 🗌 Unknown			
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rer t	ا ڠ		a. Date of Injury 28b (Month, Day, Year)	Time of 28c. Injury at	28d. Describe ho					
\$ \$	엹	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monui, Day, rear)	Injury Work?  M 1 □Yes 2	□No					
ž Ž	<u> </u>	3 ☐ Suicide 6 ☐ Could not be	e. Place of Injury - At home,	farm street factory office	28f Location (St	eet and Number or Ru	ural Clauste Alumban			
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elyf	Medical	29a. Certifier  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Check only one)								
plet	ed	one)	nd manner stated.			ne and pidoe, and due	to the cause(s)			
200	Σ	29b. Signature and title of certifier		29c. License numbe	er 29	d. Date signed (Monti	h, Day, Year)			
		10 km	mD	D003	2654	04/27/	2010			
	-	30. Name and address or person who completed cause of death (Item 23a) (Type, Print)  Juhn Serlemits 0.5 MD, 2033 Penderbrooke Dr., Crownsville, MD  31. Date filed (Month, Day, Year)  32. Redistrar's Signature								
		50. Ivaine and address or person who complet	1 5- 1	(Type, Print)	lastonate 1	( (	2032			
)		21 Data filed (Marth St. Vand	lemitsos i	MD, 2033 Pen	ecer Drooke Di	LOWNS	VIIIE, MID			
A7 4-1	А	31. Date filed (Month, Day, Year)	32. Redistrar's Signature	1. pare		-	•			
Stat legistra		APR 2 8 2010	MF3 A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 827AM HARRISON III 2010 WILLIAM Α, ADR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE'S T.ANHAM DOCTORS HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Months Days Hours Min. JAN 5 1950 WASHINGTON, DC Director 60 577-64-2052 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hyglene. In Propertment of Health and Mental Hyglene In Inportant: If item 27 is marked or ther than "natural", or items 23a or 28a-f si Important: If item 27 is marked or ther than "natural", or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. tx☐ Yes 2 ☐ No PRINCE GEORGE'S BOWIE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20716 USA 16010 EXCALIBUR ROAD # D011 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ARMY Completed by 1 X Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL BUS DRIVER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ WILLIAM A. HARRISON JR. QUEEN WADDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) QUEEN WADDY/MOTHER RAY LEONARD ROAD LANDOVER, MARYLAND 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 5/7/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J.B. JENKINS FUNERAL HOME of F neral ervice in ensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the di Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Medical resulting in death) Due to (or as a consequence of): **Examiner** INKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit nkiram that initiated events resulting in death) Last signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕰 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 N 2 🖺 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature/and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2010 D 22 61131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

MAY 0 4 2010

32. Registrar Signat

8118 GOODLUCK ROAD LANHAM, MARYLAND 20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Emelinda Hernandez М Medical 1955 <u>April</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Surburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Bill... (Month, Day, Yea 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min Director 066-60-7434 Puerto Rico 50 Sept. 1959 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Rockville 1 X Yes 2 ☐ No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11312 Hounds Way 20852 Puerto Rico Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 🕱 Yes 2 □ No Specify: Puerto Rican Specify: Puerto Rican If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Recreations Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roque Herandez Francisca Ayala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Roxboro Place NW Washington, DC 20011 Thomas Ayala/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. April 30, 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery Washington, DC 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death hysician/ disease or condition resulting in death) Subarachnoid Hemorrhage Medical Due to (or as a consequence of) Examiner <u>Intracerebral Aneurysm</u> Immediate Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year hed 9 Unknown 9 Unknown PO þ cate has been signed i page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an I or Attending Physician: The law after death.
Director: After this certificate has I autopsy performed 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ Yes 1 X Inpatient 2 ER/Outpatient 3 DOA of . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury Sion work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital 24 hours a Funeral I Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis only or Certifying Nurse Practioner: 29b. Signature 29c. License number D42818 April 26, 2010 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) Enrique Daza Racines 6420 Rockledge Drive Suite 2500 Bethesda, Md. 20817

Registrar

State

31. Date filed (Month, Day, Year

MAY 0 4 2010

32. Registrar's Signatu

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene														
		1 - State Cer					rtificate of Death					Reg. No.? () () 5500			
	1. Decedent's Name (First, Middle, Last)  Physician/  Pohert Carlton Hill					2. Date of Dea Month									
	Medical							00.	April	26, 2010			4:15 P M		
	Examin	er	4a. Facility Name (if not institution,	-	•		4b. City, Town	, or Location : Lau			40	County of		George's	
_	Funeral		Cherry Lane No 5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Ye			8. Date of Bi	rth	Q		lace (State or Foreign	
	Director		579-46-7555	1 🖾 M 2 🗆 F	72	Yrs.	Months Day	/s Hours	Min.	July 2	ay, Year)	937 Š	Count		
	ow t		Usual Residence of Decedent  10a. State 10b. County		Line										
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	vith th		9001 Cherry La	ane			101. Zip 000	2070	R			Inited	_	ates	
	eath v	Funeral	11. Marital Status	12. Was Deceder			Vas Decedent o	f Hispanic Ori	igin? (Spe	ecify Yes or No		14. Race			
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8	ursal tural" al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates	S.	'	Yes 2	No Specify:	ř					ican	
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12	rithin iene.	ပ္ပ	Elementary/Seconday (0-12) 12th	College (1-4 o	or 5+)	iire, Do	NOT use retire Youth (	-/	or			Gove	rnm	ent	
þ	iled worthed w	Be	17. Father's Name (First, Middle, L	ast)				1		e (First, Middle	, Maiden				
Maryland 21215-0036	should be file h and Mental h 7 is marked o raumatic eve	입		Earle Hil	1					Ionc Ra	and				
lan	shoul and l is ma		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Stre	et and Numbe	er or Rura	l Route Numbe	er, City o	r Town, State	e, Zip C	ode)	
≥,	ind 2 lealth m 27		Alexis Hill Whi	.te/ Daught	- T		Scaffol	ld Way	0de	nton,	Mary	1and	211	13	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1   Burial 2 □ Cremation	3 Removal from Sta		Place of Disport emetery, crem	sition (Name of natory or other p	olace)		y 3,	20c. L	ocation - Cit	y or To	wn, State	
Ę	it. Pag rtmen rtant: njury		4 Donation 5 Other (S		G1		Cemete		20	10		Washin			
Ba	permi Depar Impor any ir once.		21. Signature of Funeral Service Li	censee,	11-		Name and Add								
4001 Benning Rd. NE Washington, DC 200								20019 Approximate							
shock, or heart failure. List only one cause on each line.								Interval Between Onset and Death							
	Medical		disease or condition resulting in death)	_ a	as a consequ		cension						+		
	Examiner	L	Sequentially list conditions,	h											
	D #=	Examiner	if any, leading to immediate	Due to (or a	as a consequ	ience of):									
	and trans	xan	Cause (Disease or linjury that initiated events resulting in death) Last	(Disease or iinjury itiated events c									1		
_	death certificate be executed ne attending physician and ed for use as the burial-transit	al E	resulting in death) Last	Due to (or e	as a consequ	ierice oi).									
760	cate t	edical		d									$\pm$		
89	ath certific attending p I for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			1= - 7 - 5				J	23d. Date o	f delive	rv	
gox	leath e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birt	t at time of d		Ectopic pregn Other (specify)					Month			
You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown    You was decedent pregnant in the past 12 months? 1   Yes 2   No 9															
ď.	s tha igned be de	by	Part II. Other significant conditio	ns contributing to death	h but not resi	ulting in the u	nderlying cause	given in Part	I.					e cause of death?	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobaccomposition of the property of the pro							Yes 2	□ No 3L	_l Prob	ably 4 🖾 Unknown					
00	24a. Was an autopsy performed? 1 Yes 2 No 1 1							to con	autopsy findings available co completion of cause of						
performed 7 1 Per s 2 Page 1								o 1 $\Box$	ath? ☑ Yes 2 ☑ No						
ita	Physician: T r this certifica ral director, p	m	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:				Place of Dear							
₹ 2	y Physer this eral d	e: To	27. Manner of Death	28a. Date of in	njury	ER/Outpatien 28b. Time of	28c. In	4 L4 Nu		me 5 Resi			pecify)		
nC C	nding ath. r: Afte e fun	icat	1 ♣Natural 5 ☐ Pending 2 ☐ Accident Investig		Day, Year)	injury		ork? □ Yes 2 □	- 1			,			
isi	er des ector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)								(Street and Number or Rural Route Number,				
ă	ital or aft and Ital or aft and Ital or after an	a C													
	Hosp 24 hou Fune ted fil	ledical	29a. Certifier (Check (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								se(s) and manner stated.				
	o the vithin (	≥	only one) 3 Certifying  29b. Signature and title of certifier	g Nurse Practioner: To the best of my knowledge, d			death occurred at the time, date and place, 29c. License number			ce, and due to the cause(s) and ma			ner as stated.		
	⊢≶⊨ŏ		· WA	Wh				5217			29d. Date signed (Month, Day, Year)  April 30, 2010				
0	1/		30. Name and address of person w	/ho completed cause or	f death (Item	23a) (Type. P					PT.			~~	
12	7		Adebowale Zsaac		,	, , , , ,	,	Rd. Su	ite	M18 C	011e	ge Par	k.	Md. 20740	
	Stat		31. Date filed (Month, Day, Year)		strar's Signat	ure									
	Registra	ir	MAY 0 4 2010 A	Keeva D.	ATTAL										

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